



Group Medical Coverage Agreement

for

City Of Seattle - Deductible Plan

Group Health Cooperative (also referred to as "GHC") is a nonprofit health maintenance organization furnishing health care coverage on a prepayment basis. The Group identified below wishes to purchase such coverage. This Agreement sets forth the terms under which that coverage will be provided, including the rights and responsibilities of the contracting parties; requirements for enrollment and eligibility; and benefits to which those enrolled under this Agreement are entitled.

The Agreement between GHC and the Group consists of the following:

- Standard Provisions
- Attached Benefit Booklet
- Signed Group application
- Premium Schedule
- All attachments and endorsements included or issued hereafter

Group Health Cooperative

Signed: _____

A handwritten signature in black ink, appearing to read "John D. Mumbury", is written over a horizontal line.

Title: President and Chief Executive Officer _____

City Of Seattle - Deductible Plan, 0961000, 4961000

Signed: _____

Title: _____

This Agreement will become effective January 1, 2006 and will continue in effect until terminated or renewed as herein provided for.



**Group Medical Coverage Agreement
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Standard Provisions

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Standard Provisions

1. GHC agrees to provide benefits as set forth in the attached Benefit Booklet to enrollees of the Group.
2. **Monthly Premium Payments.** For the initial term of this Agreement, the Group shall submit to GHC for each Member the monthly premiums set forth in the current Premium Schedule and a verification of enrollment. Payment must be received on or before the due date and is subject to a grace period of ten (10) days. Premiums are subject to change by GHC upon thirty (30) days written notice. Premium rates will be revised as a part of the annual renewal process.

In the event the Group increases or decreases enrollment at least twenty-five percent (25%) or more, GHC reserves the right to require re-rating of the Group.

3. **Dissemination of Information.** Unless the Group has accepted responsibility to do so, GHC will disseminate information describing benefits set forth in the Benefit Booklet attached to this Agreement.
4. **Identification Cards.** GHC will furnish cards, for identification purposes only, to all Members enrolled under this Agreement.
5. **Administration of Agreement.** GHC may adopt reasonable policies and procedures to help in the administration of this Agreement. GHC reserves the right to construe the provisions of this Agreement and make all determinations regarding benefit entitlement and coverage.
6. **Modification of Agreement.** Except as required by federal and Washington State law, this Agreement may not be modified without agreement between both parties.

No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this Agreement, convey or void any coverage, increase or reduce any benefits under this Agreement or be used in the prosecution or defense of a claim under this Agreement.

7. **Indemnification.** GHC agrees to indemnify and hold the Group harmless against all claims, damages, losses and expenses, including reasonable attorney's fees, arising out of GHC's failure to perform, negligent performance or willful misconduct of its directors, officers, employees and agents of their express obligations under this Agreement.

The Group agrees to indemnify and hold GHC harmless against all claims, damages, losses and expenses, including reasonable attorney's fees, arising out of the Group's failure to perform, negligent performances or willful misconduct of its directors, officers, employees and agents of their express obligations under this Agreement.

The indemnifying party shall give the other party prompt notice of any claim covered by this section and provide reasonable assistance (at its expense). The indemnifying party shall have the right and duty to assume the control of the defense thereof with counsel reasonably acceptable to the other party. Either party may take part in the defense at its own expense after the other party assumes the control thereof.

8. **Compliance With Law.** The Group and GHC shall comply with all applicable state and federal laws and regulations in performance of this Agreement.

This Agreement is entered into and governed by the laws of Washington State, except as otherwise pre-empted by ERISA and other federal laws.

9. **Governmental Approval.** If GHC has not received any necessary government approval by the date when notice is required under this Agreement, GHC will notify the Group of any changes once governmental approval has been received. GHC may amend this Agreement by giving notice to the Group upon receipt of government approved rates, benefits, limitations, exclusions or other provisions, in which case such rates, benefits, limitations, exclusions or provisions will go into effect as required by the governmental agency. All

amendments are deemed accepted by the Group unless the Group gives GHC written notice of non-acceptance within thirty (30) days after receipt of amendment, in which event this Agreement and all rights to services and other benefits terminate the first of the month following thirty (30) days after receipt of non-acceptance.

- 10. Confidentiality.** Each party acknowledges that performance of its obligations under this Agreement may involve access to and disclosure of data, procedures, materials, lists, systems and information, including medical records, employee benefits information, employee addresses, social security numbers, e-mail addresses, phone numbers and other confidential information regarding the Group's employees (collectively the "information"). The information shall be kept strictly confidential and shall not be disclosed to any third party other than: (i) representatives of the receiving party (as permitted by applicable state and federal law) who have a need to know such information in order to perform the services required of such party pursuant to this Agreement, or for the proper management and administration of the receiving party, provided that such representatives are informed of the confidentiality provisions of this Agreement and agree to abide by them, (ii) pursuant to court order or (iii) to a designated public official or agency pursuant to the requirements of federal, state or local law, statute, rule or regulation. The disclosing party will provide the other party with prompt notice of any request the disclosing party receives to disclose information pursuant to applicable legal requirements, so that the other party may object to the request and/or seek an appropriate protective order against such request. Each party shall maintain the confidentiality of medical records and confidential patient and employee information as required by applicable law.
- 11. Arbitration.** In the event of a dispute or misunderstanding between the parties regarding any term of this Agreement, the parties shall first attempt to resolve the dispute through amicable negotiations, if possible. If the parties are unable to resolve the dispute informally, either party may request mediation of the dispute.

The parties shall agree on a mediator who shall conduct the mediation within sixty (60) days of the request, unless extended by agreement of the parties. The mediation shall be conducted under such terms and procedures as determined by the mediator. Any positions expressed by the parties and recommendations of the mediator shall not be admissible as evidence in any subsequent legal or alternative dispute resolution proceeding. Unless waived by the parties, an attempt to mediate the dispute is a condition precedent to pursuing any other legal remedy. If the dispute is not resolved by the mediation, either party shall be entitled to pursue any legal remedy available.

12. HIPAA.

Definition of Terms. Terms used, but not otherwise defined, in this Section shall have the same meaning as those terms have in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Transactions Accepted. GHC will accept Standard Transactions, pursuant to HIPAA, if the Group elects to transmit such transactions. If the Group sends transactions to GHC that do not comply with applicable HIPAA standards, the Group will be deemed by such action to be representing and warranting that it is not a Covered Entity or otherwise required to comply with HIPAA standards for electronic transactions, either directly, or as an agent of another individual or entity. The parties agree that all the terms, conditions, representations and warranties contained in this section are express obligations of the Group, and the Group shall indemnify GHC for any breach of this section.

- 13. Termination of Entire Agreement.** This is a guaranteed renewable Agreement and cannot be terminated without the mutual approval of each of the parties, except in the circumstances set forth below.
- a. Nonpayment or Non-Acceptance of Premium.** Failure to make any monthly premium payment or contribution in accordance with subsection 2 above shall result in termination of this Agreement as of the premium due date. The Group's failure to accept the revised premiums provided as part of the annual renewal process shall be considered nonpayment and result in non-renewal of this Agreement. The Group may terminate this Agreement upon fifteen (15) days written notice of premium increase, as set forth in subsection 2 above.

- b. Misrepresentation.** GHC may rescind or terminate this Agreement upon written notice in the event that material misrepresentation, fraud or omission of information was used in order to obtain Group coverage. Either party may terminate this Agreement in the event of material misrepresentation, fraud or omission of information by the other party in performance of its responsibilities under this Agreement.
- c. Underwriting Guidelines.** GHC may terminate or non-renew this Agreement in the event the Group no longer meets underwriting guidelines established by GHC that were in effect at the time the Group was accepted.

14. Withdrawal or Cessation of Services.

- a. GHC may determine to withdraw from a Service Area or from a segment of its Service Area after GHC has demonstrated to the Washington State Office of the Insurance Commissioner that GHC's clinical, financial or administrative capacity to service the covered Members would be exceeded.
- b. GHC may determine to cease to offer the Group's current plan and replace the plan with another plan offered to all covered Members within that line of business that includes all of the health care services covered under the replaced plan and does not significantly limit access to the services covered under the replaced plan. GHC may also allow unrestricted conversion to a fully comparable GHC product.

GHC will provide written notice to each covered Member of the discontinuation or non-renewal of the plan at least ninety (90) days prior to discontinuation.

Dear Group Health Subscriber:

This booklet contains important information about your healthcare plan.

This is your 2006 Group Health Benefit Booklet (Certificate of Coverage). It explains the services and benefits you and those enrolled on your contract are entitled to receive from Group Health Cooperative. Sections of this document may be ***bolded and italicized***, which identifies changes that Group Health has made to the plan. The benefits reflected in this booklet were approved by your employer or association who contracts with Group Health for your healthcare coverage. If you are eligible for Medicare, please read Section IV.J. as it may affect your prescription drug coverage.

We recommend you read it carefully so you'll understand not only the benefits, but the exclusions, limitations, and eligibility requirements of this certificate. Please keep this certificate for as long as you are covered by Group Health. We will send you revisions if there are any changes in your coverage.

This certificate is not the contract itself; you can contact your employer or group administrator if you wish to see a copy of the contract (Medical Coverage Agreement).

We'll gladly answer any questions you might have about your Group Health benefits. Please call our Group Health Customer Service Center at 901-4636 in the Seattle area, or toll-free in Washington, 1-888-901-4636.

Thank you for choosing Group Health Cooperative. We look forward to working with you to preserve and enhance your health.

Very truly yours,

Scott Armstrong
President

CA-1888a
CA-2370, CA-2312ad, CA-2092, CA-2073, CA-2796, CA-2079, CA-2798, CA-1385ad02, CA-1397ad, CA-2240,elg135

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Section I. Introduction

Group Health Cooperative (also referred to as “GHC”) is a nonprofit health maintenance organization furnishing health care primarily on a prepayment basis.

Read This Benefit Booklet Carefully

This Benefit Booklet is a statement of benefits, exclusions and other provisions, as set forth in the Group Medical Coverage Agreement (“Agreement”) between GHC and the employer or Group.

A full description of benefits, exclusions, limits and Out-of-Pocket Expenses can be found in the Schedule of Benefits, Section IV; General Exclusions, Section V; and Allowances Schedule, Section II. These sections must be considered together to fully understand the benefits available under the Agreement. Words with special meaning are capitalized. They are defined in Section VIII.

A. Accessing Care

Members are entitled to Covered Services only at GHC Facilities and from GHC Personal Physicians. Except as follows:

- Emergency care,
- Self-Referral to women’s health care providers, as set forth below,
- Visits with GHC-Designated Self-Referral Specialists, as set forth below,
- Care provided pursuant to a Referral. Referrals must be requested by the Member’s Personal Physician and approved by GHC, and
- Other services as specifically set forth in the Allowances Schedule and Section IV.

Primary Care. Members must select a GHC Personal Physician when enrolling under the Agreement. One Personal Physician may be selected for an entire family, or a different Personal Physician may be selected for each family member. If the Personal Physician is not selected at the time of enrollment, GHC will assign a Personal Physician, and a letter of explanation will be sent to the Member.

Selecting a Personal Physician or changing from one Personal Physician to another can be accomplished by contacting GHC Customer Service, or accessing the GHC website at www.ghc.org. The change will be made within twenty-four (24) hours of the receipt of the request, if the selected physician’s caseload permits.

A listing of GHC Personal Physicians, Referral specialists, women’s health care providers and GHC-Designated Self-Referral Specialists is available by contacting GHC Customer Service at (206) 901-4636 or (888) 901-4636, or by accessing GHC’s website at www.ghc.org.

In the case that the Member’s Personal Physician no longer participates in GHC’s network, the Member will be provided ***access to the Personal Physician for up to sixty (60) days following*** a written notice offering the Member a selection of new Personal Physicians from which to choose.

Specialty Care. Unless otherwise indicated in this section, the Allowances Schedule or Section IV., Referrals are required for specialty care and specialists.

GHC-Designated Self-Referral Specialist. Members may make appointments directly with GHC-Designated Self-Referral Specialists at Group Health-owned or -operated medical centers without a Referral from their Personal Physician. Self-Referrals are available for the following specialty care areas: allergy, audiology, cardiology, chemical dependency, chiropractic/manipulative therapy, dermatology, gastroenterology, general surgery, hospice, manipulative therapy, mental health, nephrology, neurology, obstetrics and gynecology, occupational medicine*, oncology/hematology, ophthalmology, optometry, orthopedics, otolaryngology (ear, nose and throat), physical therapy*, smoking cessation, speech/language and learning services* and urology.

* Medicare patients need a Referral for these specialists.

Women's Health Care Direct Access Providers. Female Members may see a participating General and Family Practitioner, Physician's Assistant, Gynecologist, Certified Nurse Midwife, Licensed Midwife, Doctor of Osteopathy, Pediatrician, Obstetrician or Advanced Registered Nurse Practitioner who is contracted by GHC to provide women's health care services directly, without a Referral from their Personal Physician, for Medically Necessary maternity care, covered reproductive health services, preventive care (well care) and general examinations, gynecological care and follow-up visits for the above services. Women's health care services are covered as if the Member's Personal Physician had been consulted, subject to any applicable Cost Shares, as set forth in the Allowances Schedule. If the Member's women's health care provider diagnoses a condition that requires Referral to other specialists or hospitalization, the Member or her chosen provider must obtain preauthorization and care coordination in accordance with applicable GHC requirements.

Second Opinions. The Member may access, upon request, a second opinion regarding a medical diagnosis or treatment plan from a GHC Provider.

Emergent and Urgent Care. Emergent care is available at GHC Facilities. If Members cannot get to a GHC Facility, Members may obtain Emergency services from the nearest hospital. Members or persons assuming responsibility for a Member must notify GHC by way of the GHC Emergency Notification Line within twenty-four (24) hours of admission to a non-GHC Facility, or as soon thereafter as medically possible. Members may refer to Section IV. for more information about coverage of Emergency services.

In the GHC Service Area, urgent care is covered only at GHC medical centers, GHC urgent care clinics or GHC Provider's offices. Urgent care received at any hospital emergency department is not covered unless authorized in advance by a GHC Provider. Members may refer to Section IV. for more information about coverage of urgent care services.

Outside the GHC Service Area, urgent care is covered at any medical facility. Members may refer to Section IV. for more information about coverage of urgent care services.

Recommended Treatment. GHC's Medical Director or his/her designee will determine the necessity, nature and extent of treatment to be covered in each individual case and the judgment, made in good faith, will be final.

Members have the right to participate in decisions regarding their health care. A Member may refuse any recommended treatment or diagnostic plan to the extent permitted by law. Members who obtain care not recommended by GHC, do so with the full understanding that GHC has no obligation for the cost, or liability for the outcome, of such care. Coverage decisions may be appealed as set forth in Section VI.

Major Disaster or Epidemic. In the event of a major disaster or epidemic, GHC will provide coverage according to **GHC's** best judgment, within the limitations of available facilities and personnel. GHC has no liability for delay or failure to provide or arrange Covered Services to the extent facilities or personnel are unavailable due to a major disaster or epidemic.

Unusual Circumstances. If the provision of Covered Services is delayed or rendered impossible due to unusual circumstances such as complete or partial destruction of facilities, military action, civil disorder, labor disputes or similar causes, GHC shall provide or arrange for services that, in the reasonable opinion of GHC's Medical Director, or his/her designee, are emergent or urgently needed. In regard to nonurgent and routine services, GHC shall make a good faith effort to provide services through its then-available facilities and personnel. GHC shall have the option to defer or reschedule services that are not urgent while its facilities and services are so affected. In no case shall GHC have any liability or obligation on account of delay or failure to provide or arrange such services.

B. Cost Shares

The Subscriber shall be liable for the following Cost Shares when services are received by the Subscriber and any of his/her Dependents.

- 1. Copayments.** Members shall be required to pay Copayments at the time of service as set forth in the Allowances Schedule. Payment of a Copayment does not exclude the possibility of an additional billing if the service is determined to be a non-Covered Service.

2. **Coinsurance.** After the annual Deductible is satisfied, Members shall be required to pay the plan Coinsurance for Covered Services as set forth in the Allowances Schedule.

A benefit-specific Coinsurance may apply to some Covered Services, as set forth in the Allowances Schedule. Services that are subject to the benefit-specific Coinsurance are not subject to the plan Coinsurance.

3. **Annual Deductible.** Unless otherwise noted, Covered Services are subject to an annual Deductible set forth in the Allowance Schedule. Charges subject to the annual Deductible shall be borne by the Subscriber during each calendar year until the annual Deductible is met. In order for charges to be applied to the annual Deductible, Covered Services must be obtained at GHC Facilities, unless the Member has received a Referral from a GHC Provider **which has been approved by GHC** or has received Emergency services according to the Schedule of Benefits, Section IV.L.

There is an individual annual Deductible amount for each Member and a maximum aggregate annual Deductible amount for each Family Unit. Once the aggregate annual Deductible amount is reached for a Family Unit in a calendar year, the individual annual Deductibles are also deemed reached for each Member during that same calendar year.

4. **Individual Annual Deductible Carryover.** Charges applied toward the individual annual Deductible during the months of October, November and December are also applied in an equal amount toward the Member's annual Deductible for the next calendar year. The individual annual Deductible carryover will apply only when expenses incurred have been paid in full. The aggregate Family Unit Deductible does not carry over into the next calendar year.
5. **Out-of-Pocket Limit.** Total Out-of-Pocket Expenses incurred during the same calendar year shall not exceed the Out-of-Pocket Limit set forth in the Allowances Schedule. Out-of-Pocket Expenses which apply toward the Out-of-Pocket Limit are set forth in the Allowances Schedule.
6. **Other Deductibles.** In addition to the annual Deductible, there are service-specific Deductibles when Emergency care services are received as specified in Section IV.L.

C. Subscriber's Liability

The Subscriber is liable for (1) payment to the Group of his/her contribution toward the monthly premium, if any; (2) payment of Cost Share amounts for Covered Services provided to the Subscriber and his/her Dependents, as set forth in the Allowances Schedule; and (3) payment of any fees charged for non-Covered Services provided to the Subscriber and his/her Dependents, at the time of service.

Payment of an amount billed by GHC must be received within thirty (30) days of the billing date.

D. Claims

Claims for benefits may be made before or after services are obtained. To make a claim for benefits under the Agreement, a Member (or the Member's authorized representative) must contact GHC Customer Service, or submit a claim for reimbursement as described below. Other inquiries, such as asking a health care provider about care or coverage, or submitting a prescription to a pharmacy, will not be considered a claim for benefits.

If a Member receives a bill for services the Member believes are covered under the Agreement, the Member must, within ninety (90) days of the date of service, or as soon thereafter as reasonably possible, either (1) contact GHC Customer Service to make a claim or (2) pay the bill and submit a claim for reimbursement of Covered Services to GHC, P.O. Box 34585, Seattle, WA 98124-1585. In no event, except in the absence of legal capacity, shall a claim be accepted later than one (1) year from the date of service.

GHC will generally process claims for benefits within the following timeframes after GHC receives the claims:

- Pre-service claims – within fifteen (15) days.
- Claims involving urgently needed care – within seventy-two (72) hours.
- Concurrent care claims – within twenty-four (24) hours.
- Post-service claims – within thirty (30) days.

Timeframes for pre-service and post-service claims can be extended by GHC for up to an additional fifteen (15) days. Members will be notified in writing of such extension prior to the expiration of the initial timeframe.

Section II. Allowances Schedule

The benefits described in this schedule are subject to all provisions, limitations and exclusions set forth in the Group Medical Coverage Agreement.

“Welcome” Outpatient Services Waiver

Not applicable.

Annual Deductible

\$200 per Member or \$600 per Family Unit per calendar year.

Plan Coinsurance

No plan Coinsurance.

Lifetime Maximum

\$2,000,000 per Member for Covered Services incurred, unless otherwise indicated. Up to \$5,000 is restored automatically each January 1 for benefits paid by GHC during the prior calendar year.

Hospital Services

- Covered inpatient medical and surgical services, including acute chemical withdrawal (detoxification)
Covered in full after the annual Deductible is satisfied.
- Covered outpatient hospital surgery (including ambulatory surgical centers)
Covered subject to the applicable outpatient services Copayment after the annual Deductible is satisfied.

Outpatient Services

- Covered outpatient medical and surgical services
Covered subject to a \$15 outpatient services Copayment after the annual Deductible is satisfied.
- Allergy testing
Covered subject to the applicable outpatient services Copayment after the annual Deductible is satisfied.
- Oncology (radiation therapy, chemotherapy)
Covered subject to the applicable outpatient services Copayment after the annual Deductible is satisfied.

Drugs - Outpatient (including mental health drugs, contraceptive drugs and devices and diabetic supplies)

- Prescription drugs, medicines, supplies and devices for a supply of thirty (30) days or less when listed in the GHC drug formulary
Covered subject to the lesser of the GHC’s charge or a \$15 Copayment for generic drugs, including diabetic supplies, such as insulin syringes, urine-testing reagents, blood-glucose monitoring reagents and lancets, or \$30 Copayment for brand name drugs.
- Over-the-counter drugs and medicines

Not covered.

- Allergy serum

Covered subject to the applicable prescription drug Cost Share (*as set forth above*) for each thirty (30) day supply.

- Injectables

Injections that can be self-administered are subject to the applicable prescription drug Cost Share (*as set forth above*).
Injections necessary for travel are not covered.

- Mail order drugs and medicines

Covered subject to two (2) times the applicable prescription drug Cost Share (*as set forth above*) for each ninety (90) day supply or less for mail order prescription drugs.

- Growth hormones

Covered at the applicable plan Coinsurance after the annual Deductible is satisfied.

Out-of-Pocket Limit (Stop Loss)

Limited to an aggregate maximum of \$2,000 per Member or \$6,000 per family per calendar year. Except as otherwise noted in this Allowances Schedule, the total Out-of-Pocket Expenses for the following Covered Services are included in the Out-of-Pocket Limit:

- Outpatient services
- Emergency care at a GHC Facility or non-GHC Facility
- Ambulance services

Acupuncture

Covered subject to the applicable outpatient services Copayment for Self-Referrals to a GHC Provider up to a maximum of **eight (8)** visits per Member per medical diagnosis per calendar year, after the annual Deductible is satisfied. When approved by GHC, additional visits are covered subject to the applicable outpatient services Copayment after the annual Deductible is satisfied.

Ambulance Services

- Emergency ground/air transport

Covered at 80%.

- Non-emergent ground/air interfacility transfer

Covered at 80% for GHC-initiated transfers, except hospital-to-hospital ground transfer covered in full.

Chemical Dependency

- Inpatient services

Covered **subject to the applicable inpatient services Copayment** after the annual Deductible is satisfied.

- Outpatient services

Covered subject to the applicable outpatient services Copayment after the annual Deductible is satisfied.

- Benefit period Allowance

Covered up to **\$13,000** per Member per any twenty-four (24) consecutive calendar month period.

Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.

Dental Services (including accidental injury to natural teeth)

Not covered, except as set forth in Section IV.B.24.

Devices, Equipment and Supplies (for home use)

Covered at 80% for:

- Durable medical equipment
- Orthopedic appliances
- Post-mastectomy bras limited to two (2) every six (6) months

Covered at 80% for:

- Ostomy supplies
- Prosthetic devices

Diabetic Supplies

Insulin, needles, syringes and lancets – see Drugs-Outpatient. External insulin pumps, blood glucose monitors, testing reagents and supplies - see Devices, Equipment and Supplies. When Devices, Equipment and Supplies have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit.

Diagnostic Laboratory and Radiology Services

Covered in full after the annual Deductible is satisfied.

Emergency Services

- At a GHC Facility

Covered subject to a \$75 Copayment per Member per Emergency visit, after the annual Deductible is satisfied. Copayment is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions are covered subject to the applicable inpatient services Cost Share.

- At a non-GHC Facility

Covered subject to a \$125 Deductible per Member per Emergency visit, after the annual Deductible is satisfied. Emergency care Deductible is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions are covered subject to the applicable inpatient services Cost Share.

Hearing Examinations and Hearing Aids

- Hearing examinations to determine hearing loss

Covered subject to the applicable outpatient services Copayment after the annual Deductible is satisfied.

- Hearing aids, including hearing aid examinations

Not covered.

Home Health Services

Covered in full. No visit limit.

Hospice Services

Covered in full. Inpatient respite care is covered for a maximum of five (5) consecutive days per occurrence.

Infertility Services (including sterility)

Not covered.

Manipulative Therapy

Covered subject to the applicable outpatient services Copayment for Self-Referrals to a GHC Provider for manipulative therapy of the spine *and extremities* in accordance with GHC clinical criteria up to a maximum of ten (10) visits per Member per calendar year after the annual Deductible is satisfied. When approved by GHC, additional manipulation visits are covered subject to the applicable outpatient services Copayment after the annual Deductible is satisfied.

Maternity and Pregnancy Services

- Delivery and associated Hospital Care

Covered *subject to the applicable inpatient services Copayment* after the annual Deductible is satisfied.

- Routine prenatal and postpartum care

Covered subject to the applicable outpatient services Copayment after the annual Deductible is satisfied.

- Pregnancy termination

Covered subject to the applicable outpatient services Copayment for involuntary/voluntary termination of pregnancy after the annual Deductible is satisfied.

Mental Health Services

- Inpatient services

Covered subject to the applicable inpatient services Cost Share at a GHC-approved mental health care facility.

- Outpatient services

Covered subject to the applicable outpatient services Cost Share. Copayment applies to the Out-of-Pocket Limit.

Naturopathy

Covered subject to the applicable outpatient services Copayment for Self-Referrals to a GHC Provider up to a maximum of *three (3)* visits per Member per medical diagnosis per calendar year after the annual Deductible is satisfied. When approved by GHC, additional visits are covered subject to the applicable outpatient services Copayment after the annual Deductible is satisfied.

Nutritional Services

- Phenylketonuria (PKU) supplements

Covered in full.

- Enteral therapy (formula)

Covered at 80% for elemental formulas after the annual Deductible is satisfied. Necessary equipment and supplies are covered under Devices, Equipment and Supplies. Coinsurance does not apply to the Out-of-Pocket Limit.

- Parenteral therapy (total parenteral nutrition)

Covered for parenteral formulas after the annual Deductible is satisfied. Necessary equipment and supplies are covered under Devices, Equipment and Supplies.

Obesity Related Services

Services directly related to obesity, including bariatric surgery, weight loss programs, medications and related physician visits for medication monitoring are not covered.

On the Job Injuries or Illnesses

Not covered, including injuries or illnesses incurred as a result of self-employment.

Optical Services

- Routine eye examinations

Covered subject to the applicable outpatient services Copayment once every twelve (12) months. Not subject to the annual Deductible.

- Lenses, including contact lenses, and frames

Not covered, except contact lens after cataract surgery is covered when in lieu of an intraocular lens after the annual Deductible is satisfied.

Organ Transplants

Covered subject to the applicable Cost Share.

Plastic and Reconstructive Services (plastic surgery, cosmetic surgery)

- Surgery to correct a congenital disease or anomaly, or conditions following an injury or resulting from surgery

Covered *subject to the applicable Copayment* after the annual Deductible is satisfied.

- Cosmetic surgery, including complications resulting from cosmetic surgery

Not covered.

Podiatric Services

- Medically Necessary foot care

Covered subject to the applicable outpatient services Copayment after the annual Deductible is satisfied.

- Foot care (routine)

Not covered, except in the presence of a non-related Medical Condition affecting the lower limbs.

Pre-Existing Condition

Covered with no wait.

Preventive Services (well adult and well child physicals, immunizations, pap smears, mammograms)

Covered subject to the applicable outpatient services Copayment when in accordance with the well care schedule established by GHC. Not subject to the annual Deductible. Eye refractions are not included under preventive care. Physicals for travel, employment, insurance, license, are not covered. Services provided during a preventive care visit which are not in accordance with the well care schedule are covered subject to the applicable outpatient services Copayment after the annual Deductible is satisfied.

Rehabilitation Services

- Inpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under

Covered ***subject to the applicable inpatient services Copayment and*** plan Coinsurance for up to sixty (60) days per condition per calendar year after the annual Deductible is satisfied.

- Outpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under

Covered subject to the applicable outpatient services Copayment and plan Coinsurance for up to sixty (60) visits per condition per calendar year after the annual Deductible is satisfied.

Sexual Dysfunction Services

Not covered.

Skilled Nursing Facility (SNF)

Covered for up to sixty (60) days per Member per calendar year after the annual Deductible is satisfied.

Sterilization (vasectomy, tubal ligation)

Not covered.

Temporomandibular Joint (TMJ) Services

- Inpatient and outpatient TMJ services

Covered subject to the applicable Copayment for up to \$1,000 maximum per Member per calendar year after the annual Deductible is satisfied.

- Lifetime benefit maximum

Covered up to \$5,000 per Member.

Tobacco Cessation

- Individual/group sessions

Covered in full.

- Approved pharmacy products

Covered subject to the lesser of GHC's charge or the applicable prescription drug Cost Share (***as set forth above in Drugs-Outpatient***) for each thirty (30) day supply or less of a prescription or refill when prescribed by a GHC Provider and obtained at a GHC Facility.

Section III. Eligibility, Enrollment and Termination

A. Eligibility

In order to be accepted for enrollment and continuing coverage under the Agreement, individuals must meet any eligibility requirements imposed by the Group, and/or all applicable plan documents, reside or work in the Service Area and meet all applicable requirements set forth below, except for temporary residency outside the Service Area for purposes of attending school, court-ordered coverage for Dependents or other unique family arrangements, when approved in advance by GHC. GHC has the right to verify eligibility.

1. **Subscribers.** An active, regular full-time employee who works at least eighty (80) hours per month or a temporary employee in a benefits-eligible assignment who works at least eighty (80) hours per month is eligible to obtain City-paid contributions for coverage. A temporary employee who has worked at least 1,040 cumulative, non-overtime hours and at least 800 non-overtime hours in the previous twelve (12) month period, and is not in a benefits-eligible assignment is eligible for coverage.

An employee for whom coverage already became effective, but who is absent without pay on the first day of the calendar month and returns by the fifteenth (15th) of the month will not have a lapse in coverage. Coverage for an employee who returns after the fifteenth (15th) of the month will begin the first day of the following calendar month. However, an employee who is absent without pay for fifteen (15) consecutive calendar days or less will not have a lapse in coverage.

2. **Dependents.** The Subscriber may also enroll the following:

- a. The Subscriber's legal spouse (unless legally separated).
- b. The Subscriber's domestic partner, provided that the application has been submitted to and approved by the Group and GHC, and that the Subscriber and domestic partners:
 - i. Share the same regular and permanent residence;
 - ii. Have a close personal relationship;
 - iii. Are jointly responsible for "basic living expenses" as defined by the Group;
 - iv. Are not married to anyone;
 - v. Are each eighteen (18) years of age or older;
 - vi. Are not related by blood closer than would bar marriage in the State of Washington;
 - vii. Were mentally competent to consent to contract when the domestic partnership began; and
 - viii. Are each other's sole domestic partner and are responsible for each other's common welfare.

Following termination of a domestic partnership a statement of termination must be filed with the Group. Application for another domestic partnership cannot be filed for ninety (90) days following a filing of the statement of termination of domestic partnership with the Group, unless such termination is due to the death of the domestic partner.

- c. Unmarried natural children, legally adopted children, children legally placed for adoption, step-children, children of a domestic partner, or children whose custody has been awarded to the Subscriber by a court of competent jurisdiction, who are under the age of twenty-one (21) and are chiefly dependent on the Subscriber or spouse for support and maintenance, provided proof of such dependency is furnished to GHC.
- d. An unmarried child of a divorced Subscriber who is under the age of twenty-one (21), whether or not the child is primarily dependent upon the subscriber for support (provided the child is not primarily self-supporting), if the divorced Subscriber is legally responsible for providing the child's health care.
- e. An unmarried child for whom you elected coverage when the child was first eligible, but whose coverage terminated due to a loss of dependency status, and the child later meets the definition of a dependent again as defined in Section III.A.2.c., Section III.A.2.d., or Section III.A.4.a.

3. **Temporary Coverage for Newborns.** When a Member gives birth, the newborn will be entitled to the benefits set forth in Section IV. from birth through three (3) weeks of age. After three (3) weeks of age, no benefits are available unless the newborn child qualifies as a Dependent and is enrolled under the Agreement. All contract provisions, limitations and exclusions will apply except Section III.F. and III.G.
4. **Limiting Age Extension.** Eligibility may be extended past the limiting age for an unmarried person enrolled as a Dependent on his/her twenty-first (21st) birthday if:

The Dependent is a full-time registered student at an accredited secondary school, college, or university and under the age of twenty-three (23); or the Dependent is totally incapable of self-sustaining employment because of a developmental or physical disability incurred prior to attainment of the limiting age set forth in 2. above, and is chiefly dependent upon the Subscriber for support and maintenance. Enrollment for such a Dependent may be continued for the duration of the continuous total incapacity, provided enrollment does not terminate for any other reason. Medical proof of incapacity and proof of financial dependency must be furnished to GHC upon request, but not more frequently than annually after the two (2) year period following the Dependent's attainment of the limiting age.

B. Enrollment

1. **Application for Enrollment.** Application for enrollment must be made on an application form furnished or approved by GHC. Applicants will not be enrolled or premiums accepted until the completed application form has been received and approved by GHC. The Group is responsible for submitting completed application forms to GHC.

GHC reserves the right to refuse enrollment to any person whose coverage under any Medical Coverage Agreement issued by Group Health Cooperative or Group Health Options, Inc. has been terminated for cause, as set forth in Section III.E. below.

- a. **Newly Eligible Persons.** Newly eligible Subscribers and their Dependents may apply for enrollment in writing to the Group within thirty-one (31) days of becoming eligible. Temporary employees and their Dependents who are not in a benefits-eligible assignment may apply for enrollment in writing to the Group within ninety (90) days of becoming eligible.
- b. **New Dependents.** A written application for enrollment of a newly dependent person, other than a newborn or adopted newborn child, must be made to the Group within thirty-one (31) days after the dependency occurs.

A written application for enrollment of a newborn child must be made to the Group within sixty (60) days following the date of birth, when there is a change in the monthly premium payment as a result of the additional Dependent.

A written application for enrollment of an adoptive child must be made to the Group within sixty (60) days from the day the child is placed with the Subscriber for the purpose of adoption and the Subscriber assumes financial responsibility for the medical expenses of the child, if there is a change in the monthly premium payment as a result of the additional Dependent.

When there is no change in the monthly premium payment, it is strongly advised that the Subscriber enroll the newborn or newly adoptive child as a Dependent with the Group to avoid delays in the payment of claims.

- c. **Open Enrollment.** GHC will allow enrollment of Subscribers and Dependents, who did not enroll when newly eligible as described above, during a limited period of time specified by the Group and GHC.
- d. **Special Enrollment.** GHC will allow special enrollment for persons who initially declined enrollment when *otherwise* eligible because such persons had other health care coverage and have had such other coverage terminated due to cessation of employer contributions, exhaustion of COBRA continuation coverage or loss of eligibility, except for loss of eligibility for cause; *or have had such other coverage exhausted because such person reached a Lifetime Maximum limit.* GHC or the Group may require confirmation that when initially offered coverage such persons submitted a written statement declining because of other coverage. Application for coverage under the Agreement must be made within thirty-one (31) days of the termination of previous coverage.

In the event a Subscriber or person eligible to be a Subscriber acquires a person eligible to be a Dependent by birth, marriage, adoption or placement for adoption, GHC will allow special enrollment for the person eligible to be a Subscriber, his/her spouse and the newly acquired Dependent. Application for coverage under the Agreement must be made within thirty-one (31) days of the acquisition of the new Dependent, except that sixty (60) days is permitted to enroll newborn and adopted children as described above.

2. **Limitation on Enrollment.** The Agreement will be open for applications for enrollment as set forth in this Section III.B. Subject to prior approval by the Washington State Office of the Insurance Commissioner, GHC may limit enrollment, establish quotas or set priorities for acceptance of new applications if it determines that GHC's capacity, in relation to its total enrollment, is not adequate to provide services to additional persons.

C. Effective Date of Enrollment

1. Provided eligibility criteria are met and applications for enrollment are made as set forth in Sections III.A. and III.B. above, enrollment will be effective as follows:
 - City-paid enrollment for a newly eligible Subscriber and listed Dependents will begin on the Subscriber's first (1st) day of employment if that date is: (a) the first (1st) calendar day of the month designated as a City business day, or (b) the first (1st) calendar day of the month designated/recognized as the first (1st) working day for the shift to which the Subscriber is assigned, whichever is later. If employment begins after said date, the Subscriber's enrollment will begin the following month.
 - Enrollment on a self-pay basis, for a newly eligible Subscriber and listed Dependents will begin on the first (1st) day of the month following the date the application is received.
 - Enrollment for temporary employees who are not in a benefits-eligible assignment will begin the first (1st) of the calendar month following the date application is made and the rate is paid, or the date designated by the Group if application is made during an open enrollment period. Enrollment for temporary employees in a benefits-eligible assignment will begin the first (1st) calendar day of the month designated as a City business day. If employment begins after said date, enrollment for the temporary employee in a benefits eligible assignment will begin the following month.
 - Enrollment for newly acquired Domestic Partners will begin on the date the affidavit is signed, and for newly acquired spouses will begin on the date of marriage.
 - Enrollment for all other newly dependent persons, other than newborns, adopted children, or children for whom the Subscriber becomes a legal guardian will begin on the first (1st) of the month following application.
 - Enrollment for newborns is effective from the date of birth.
 - Enrollment for adoptive children, children placed for adoption, or children for whom the Subscriber becomes a legal guardian is effective from the date that the adoptive child is placed with the Subscriber for the purpose of adoption, or from the date of legal guardianship, and the Subscriber has assumed financial responsibility for the medical expenses of the child.
2. **Commencement of Benefits for Persons Hospitalized on Effective Date.** Members who are admitted to an inpatient facility prior to their enrollment under the Agreement, and who do not have coverage under another agreement, will receive covered benefits beginning on their effective date, as set forth in subsection C.1. above. If a Member is hospitalized in a non-GHC Facility, GHC reserves the right to require transfer of the Member to a GHC Facility. The Member will be transferred when a GHC Provider, in consultation with the attending physician, determines that the Member is medically stable to do so. If the Member refuses to transfer to a GHC Facility, all further costs incurred during the hospitalization are the responsibility of the Member.

D. Eligibility for Medicare

Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), actively employed Members and their spouses who are eligible for Medicare benefits must decide whether to choose the benefits of the Agreement or the Medicare program as their primary source of health care coverage. The Group is responsible for providing the Member with necessary information regarding TEFRA eligibility and the selection process.

Members Residing Outside the GHC Medicare Advantage Service Area. Except as defined by federal regulations (i.e., TEFRA), if a Member or their spouse is or becomes eligible for Medicare, they must, effective the date that Medicare becomes the primary payer, enroll in and maintain both Medicare Parts A and B coverage. Failure to enroll in

both Medicare Parts A and B, upon the effective date of eligibility, will result in termination of coverage under the Agreement.

An individual shall be deemed eligible for Medicare when he/she has the option to receive Part A Medicare benefits.

Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status.

Members Residing Inside the GHC Medicare Advantage Service Area. Except as defined by federal regulations, (i.e., TEFRA), if a Member or their spouse is or becomes eligible for Medicare, they must, effective the date that Medicare becomes the primary payer, enroll in and maintain both Medicare Parts A and B coverage and enroll in the GHC Medicare Advantage Plan. Failure to do so upon the effective date of Medicare eligibility will result in termination of coverage under the Agreement.

An individual shall be deemed eligible for Medicare when he/she has the option to receive Part A Medicare benefits.

All applicable provisions of the GHC Medicare Advantage Plan are fully set forth in the Medicare Endorsement(s) attached to the Agreement (if applicable).

E. Termination of Coverage

1. Termination of Specific Members. Specific Members may be terminated from the Agreement for any of the following reasons:

- a. Loss of Eligibility.** If a Member no longer meets the eligibility requirements set forth in Section III.A., and is not enrolled for continuation coverage as described in Section III.G. below, coverage under the Agreement will terminate at the end of the month during which the loss of eligibility occurs, unless otherwise specified by the Group.
- b. For Cause.** Coverage of a Member may be terminated upon *ten (10) working days* written notice for:
 - i. Material misrepresentation, fraud or omission of information in order to obtain coverage.
 - ii. Permitting the use of a GHC identification card or number by another person, or using another Member's identification card or number to obtain care to which a person is not entitled.
 - iii. Nonpayment of charges, as set forth in Section I.C.

In the event of termination for cause, GHC reserves the right to pursue all civil remedies allowable under federal and state law for the collection of claims, losses or other damages.

- c. Premium Payments.** Nonpayment of premiums or contribution for a specific Member by the Group.

In no event will a Member be terminated solely on the basis of their physical or mental condition provided they meet all other eligibility requirements set forth in the Agreement.

Any Member may appeal a termination decision through GHC's grievance process as set forth in Section VI.

2. Certificate of Creditable Coverage. Unless the Group has chosen to accept this responsibility, a certificate of creditable coverage (which provides information regarding the Member's length of coverage under the Agreement) will be issued automatically upon termination of coverage, and may also be obtained upon request.

F. Services After Termination of Agreement

1. Members Hospitalized on the Date of Termination. A Member who is receiving Covered Services as a registered bed patient in a hospital on the date of termination shall continue to be eligible for Covered Services while an inpatient for the condition which the Member was hospitalized, until one of the following events occurs:

- According to GHC clinical criteria, it is no longer Medically Necessary for the Member to be an inpatient at the facility.
- The remaining benefits available under the Agreement for the hospitalization are exhausted, regardless of whether a new calendar year begins.

- The Member becomes covered under another agreement with a group health plan that provides benefits for the hospitalization.
- The Member becomes enrolled under an agreement with another carrier that would provide benefits for the hospitalization if the Agreement did not exist.
- The Member becomes eligible for Medicare.

This provision will not apply if the Member is covered under another agreement that provides benefits for the hospitalization at the time coverage would terminate, except as set forth in this section, or if the Member is eligible for COBRA continuation coverage as set forth in subsection G. below.

2. **Services Provided After Termination.** The Subscriber shall be liable for payment of all charges for services and items provided to the Subscriber and all Dependents after the effective date of termination, except those services covered under subsection F.1. above. Any services provided by GHC will be charged according to the Fee Schedule.

G. Continuation of Coverage Options

1. **Continuation Option.** A Member no longer eligible for coverage under the Agreement (except in the event of termination for cause, as set forth in Section III.E.) may continue coverage for a period of up to three (3) months subject to notification to and self-payment of premiums to the Group. This provision will not apply if the Member is eligible for the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This continuation option is not available if the Group no longer has active employees or otherwise terminates.
2. **Leave of Absence.** While on a Group approved leave of absence, the Subscriber and listed Dependents can continue to be covered under the Agreement provided:
 - They remain eligible for coverage, as set forth in Section III.A.,
 - Such leave is in compliance with the Group's established leave of absence policy that is consistently applied to all employees,
 - The Group's leave of absence policy is in compliance with the Family and Medical Leave Act when applicable, and
 - The Group continues to remit premiums for the Subscriber and Dependents to GHC.
3. **Self-Payments During Labor Disputes.** In the event of suspension or termination of employee compensation due to a strike, lock-out or other labor dispute, a Subscriber may continue uninterrupted coverage under the Agreement through payment of monthly premiums directly to the Group. Coverage may be continued for the lesser of the term of the strike, lock-out or other labor dispute, or for six (6) months after the cessation of work.

If the Agreement is no longer available, the Subscriber shall have the opportunity to apply for an individual GHC Group Conversion Plan or, if applicable, continuation coverage (see subsection 4. below), or an Individual and Family Medical Coverage Agreement at the duly approved rates.

The Group is responsible for immediately notifying each affected Subscriber of his/her rights of self-payment under this provision.

4. **Continuation Coverage Under Federal Law.** This section applies only to Groups who must offer continuation coverage under the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, and only applies to grant continuation of coverage rights to the extent required by federal law.

Upon loss of eligibility, continuation of Group coverage may be available to a Member for a limited time after the Member would otherwise lose eligibility, if required by COBRA. The Group shall inform Members of the COBRA election process and how much the Member will be required to pay directly to the Group.

5. **GHC Group Conversion Plan.** Members whose eligibility for coverage under the Agreement, including continuation coverage, is terminated for any reason other than cause, as set forth in Section III.E.1.b., and who are

not eligible for Medicare or covered by another group health plan, may convert to GHC's Group Conversion Plan. If the Agreement terminates, any Member covered under the Agreement at termination may convert to a GHC Group Conversion Plan, unless he/she is eligible to obtain other group health coverage within thirty-one (31) days of the termination of the Agreement.

An application for conversion must be made within thirty-one (31) days following termination of coverage under the Agreement. Coverage under GHC's Group Conversion Plan is subject to all terms and conditions of such plan, including premium payments. A physical examination or statement of health is not required for enrollment in GHC's Group Conversion Plan. The Pre-Existing Condition limitation under GHC's Group Conversion Plan will apply only to the extent that the limitation remains unfulfilled under the Agreement.

By exercising Group Conversion rights, the Member may waive guaranteed issue and Pre-Existing Condition waiver rights under Federal regulations.

Persons wishing to purchase GHC's Individual and Family coverage should contact GHC Marketing.

Section IV. Schedule of Benefits

Benefits are subject to all provisions of the Group Medical Coverage Agreement, including, without limitation, the Accessing Care provisions and General Exclusions. Members must refer to Section II., the Allowances Schedule, for Cost Shares and specific benefit limits that apply to benefits listed in this Schedule of Benefits. Members are entitled to receive only benefits and services that are Medically Necessary and clinically appropriate for the treatment of a Medical Condition as determined by GHC's Medical Director, or his/her designee, and as described herein. All Covered Services are subject to case management and utilization review at the discretion of GHC.

A. Hospital Care

Hospital coverage is limited to the following services:

1. Room and board, including private room when prescribed, and general nursing services.
2. Hospital services (including use of operating room, anesthesia, oxygen, x-ray, laboratory and radiotherapy services).
3. Alternative care arrangements may be covered as a cost-effective alternative in lieu of otherwise covered Medically Necessary hospitalization, or other covered Medically Necessary institutional care. Alternative care arrangements in lieu of covered hospital or other institutional care must be determined to be appropriate and Medically Necessary based upon the Member's Medical Condition. Coverage must be authorized in advance by GHC as appropriate and Medically Necessary. Such care will be covered to the same extent the replaced Hospital Care is covered under the Agreement.
4. Drugs and medications administered during confinement.
5. Special duty nursing, when prescribed as Medically Necessary.

If a Member is hospitalized in a non-GHC Facility, GHC reserves the right to require transfer of the Member to a GHC Facility, upon consultation between a GHC Provider and the attending physician. If the Member refuses to transfer, all further costs incurred during the hospitalization are the responsibility of the Member.

B. Medical and Surgical Care

Medical and surgical coverage is limited to the following:

1. Surgical services.
2. Diagnostic x-ray, nuclear medicine, ultrasound and laboratory services.
3. Family planning counseling services.

4. Hearing examinations to determine hearing loss.
5. Blood and blood derivatives and their administration.
6. Preventive care (well care) services for health maintenance in accordance with the well care schedule established by GHC. Preventive care includes: routine mammography screening, physical examinations and routine laboratory tests for cancer screening in accordance with the well care schedule established by GHC, and immunizations and vaccinations listed as covered in the GHC drug formulary (approved drug list). A fee may be charged for health education programs. ***The well care schedule is available in GHC clinics, by accessing GHC's website at www.ghc.org, or upon request.***

Covered Services provided during a preventive care visit, which are not in accordance with the GHC well care schedule, are subject to the applicable Cost Shares.

7. Radiation therapy services.
8. Reduction of a fracture or dislocation of the jaw or facial bones; excision of tumors or non-dental cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth; and incision of salivary glands and ducts.
9. Medical implants.

Excluded: internally implanted insulin pumps, artificial hearts, artificial larynx and any other implantable device that has not been approved by GHC's Medical Director, or his/her designee.

10. Respiratory therapy.
11. Outpatient total parenteral nutritional therapy; outpatient elemental formulas for malabsorption; and dietary formula for the treatment of phenylketonuria (PKU). Coverage for PKU formula is not subject to a Pre-Existing Condition waiting period, if applicable.

Equipment and supplies for the administration of enteral and parenteral therapy are covered under Devices, Equipment and Supplies.

Excluded: any other dietary formulas, oral nutritional supplements, special diets, prepared foods/meals and formula for access problems.

12. Visits with GHC Providers, including consultations and second opinions, in the hospital or provider's office.
13. Optical services.

Routine eye examinations and refractions received at a GHC Facility once every twelve (12) months, except when Medically Necessary.

When dispensed through GHC Facilities, one contact lens per diseased eye in lieu of an intraocular lens, including exam and fitting, is covered for Members following cataract surgery performed by a GHC Provider, provided the Member has been continuously covered by GHC since such surgery. Replacement of a covered contact lens will be covered only when needed due to a change in the Member's Medical Condition, but no more than once in a twelve (12) month period.

Excluded: evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures, and contact lens fittings and related examinations, except as set forth above.

14. Maternity care, including care for complications of pregnancy and prenatal and postpartum visits.

Prenatal testing for the detection of congenital and heritable disorders when Medically Necessary as determined by GHC's Medical Director, or his/her designee, and in accordance with Board of Health standards for screening and diagnostic tests during pregnancy.

Hospitalization and delivery, including home births for low risk pregnancies. Planned home births must be authorized in advance by GHC.

Voluntary (not medically indicated and non-therapeutic) or involuntary termination of pregnancy.

The Member's physician, in consultation with the Member, will determine the Member's length of inpatient stay following delivery. Pregnancy will not be excluded as a Pre-Existing Condition under the Agreement. Treatment for post-partum depression or psychosis is covered only under the mental health benefit.

Excluded: birthing tubs and genetic testing of non-Members for the detection of congenital and heritable disorders.

15. Transplant services, including heart, heart-lung, single lung, double lung, kidney, pancreas, cornea, intestinal/multi-visceral, bone marrow, liver transplants and stem cell support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high dose chemotherapy. Services are limited to the following:
 - a. Evaluation testing to determine recipient candidacy,
 - b. Matching tests,
 - c. Inpatient and outpatient medical expenses listed below for transplantation procedures. Covered Services must be directly associated with, and occur at the time of, the transplant. The following transplantation expenses are covered as set forth in the Allowances Schedule:
 - Hospital charges,
 - Procurement center fees,
 - Professional fees,
 - Travel costs for a surgical team,
 - Excision fees,
 - Donor costs for a covered organ recipient are limited to procurement center fees, travel costs for a surgical team and excision fees.
 - d. Follow-up services for specialty visits,
 - e. Rehospitalization, and
 - f. Maintenance medications.

Excluded: donor costs to the extent that they are reimbursable by the organ donor's insurance, treatment of donor complications, living expenses and transportation expenses, except as set forth under Section IV.M.

16. Manipulative therapy.

Self-Referrals for manipulative therapy of the spine **and extremities** are limited to one (1) evaluation and ten (10) manipulations when provided by GHC Providers.

Additional visits are covered when approved by GHC.

Excluded: supportive care rendered primarily to maintain the level of correction already achieved, care rendered primarily for the convenience of the Member, care rendered on a non-acute, asymptomatic basis, charges for office visits other than the initial evaluation and any other services that do not meet GHC clinical criteria as Medically Necessary.

17. Medical and surgical services and related hospital charges, including orthognathic (jaw) surgery, for the treatment of temporomandibular joint (TMJ) disorders. Such disorders may exhibit themselves in the form of pain, infection, disease, difficulty in speaking or difficulty in chewing or swallowing food. TMJ appliances are covered as set forth under Section IV.H.1., Orthopedic Appliances.

Orthognathic (jaw) surgery for the treatment of TMJ disorders, radiology services and TMJ specialist services, including fitting/adjustment of splints are subject to the benefit limit set forth in the Allowances Schedule.

Excluded are the following, regardless of origin or cause: orthognathic (jaw) surgery in the absence of a TMJ or severe obstructive sleep apnea diagnosis *except for newborn infants with congenital anomalies*, treatment for cosmetic purposes, dental services, including orthodontic therapy and any hospitalizations related to these exclusions.

18. Treatment of growth disorders by growth hormones.
19. Diabetic training and education.
20. Detoxification services for alcoholism and drug abuse.

For the purposes of this section, "acute chemical withdrawal" means withdrawal of alcohol and/or drugs from a Member for whom consequences of abstinence are so severe that they require medical/nursing assistance in a hospital setting, which is needed immediately to prevent serious impairment to the Member's health.

Coverage for acute chemical withdrawal is provided without prior approval. If a Member is hospitalized in a non-GHC Facility/program, coverage is subject to payment of the Emergency Deductible. The Member or person assuming responsibility for the Member must notify GHC by way of the GHC Notification Line within twenty-four (24) hours following inpatient admission, or as soon thereafter as medically possible. Furthermore, if a Member is hospitalized in a non-GHC Facility/program, GHC reserves the right to require transfer of the Member to a GHC Facility/program upon consultation between a GHC Provider and the attending physician. If the Member refuses transfer to a GHC Facility/program, all further costs incurred during the hospitalization are the responsibility of the Member.

21. Circumcision.
22. Nutritional counseling provided by GHC staff.
23. Therapeutic sterilization procedures.
24. General anesthesia services and related facility charges for dental procedures will be covered for Members who are under seven (7) years of age, or are physically or developmentally disabled or have a Medical Condition where the Member's health would be put at risk if the dental procedure were performed in a dentist's office. Such services must be authorized in advance by GHC and performed at a GHC hospital or ambulatory surgical facility.

Excluded: dentist's or oral surgeon's fees.

25. Self-Referrals to GHC acupuncturists and naturopaths for Covered Services, as set forth in the Allowances Schedule. Additional visits are covered when approved by GHC. Laboratory and radiology services are covered only when obtained through a GHC Facility.

Excluded: herbal supplements, preventive care visits to acupuncturists and naturopaths and any services not within the scope of their licensure.

26. Once Pre-Existing Condition wait periods, if any, have been met, Pre-Existing Conditions are covered in the same manner as any other illness.

C. Chemical Dependency Treatment.

Chemical dependency means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages, and where the user's health is substantially impaired or endangered or his/her social or economic function is substantially disrupted.

For the purposes of this section, the definition of Medically Necessary shall be expanded to include those services necessary to treat a chemical dependency condition that is having a clinically significant impact on a Member's emotional, social, medical and/or occupational functioning.

Chemical dependency treatment services are covered as set forth below at a GHC Facility or GHC-approved treatment program, subject to the benefit period Allowance set forth in the Allowances Schedule. Any Cost Shares for chemical dependency services under the terms of the Agreement shall not be applied toward the benefit period Allowance.

1. **Chemical Dependency Treatment Services.** All alcoholism and/or drug abuse treatment services must be: (a) provided at a facility as described above; and (b) deemed Medically Necessary as defined above. Chemical dependency treatment may include the following services received on an inpatient or outpatient basis: diagnostic evaluation and education, organized individual and group counseling and/or prescription drugs and medicines.

Court-ordered treatment shall be covered only if determined to be Medically Necessary as defined above.

2. **Benefit Period.** For the purposes of this section, "benefit period" shall mean a twenty-four (24) consecutive calendar month period during which the Member is eligible to receive covered chemical dependency treatment services, as set forth in this section. The first benefit period shall begin on the first day the Member receives covered chemical dependency services and shall continue for twenty-four (24) consecutive calendar months, provided that coverage under the Agreement remains in force. All subsequent benefit periods thereafter will begin on the first day Covered Services are received after the expiration of the previous twenty-four (24) month benefit period.

D. Plastic and Reconstructive Services. Plastic and reconstructive services are covered as set forth below:

1. Correction of a congenital disease or congenital anomaly, as determined by a GHC Provider. A congenital anomaly will be considered to exist if the Member's appearance resulting from such condition is not within the range of normal human variation.
2. Correction of a Medical Condition following an injury or resulting from surgery covered by GHC which has produced a major effect on the Member's appearance, when in the opinion of a GHC Provider, such services can reasonably be expected to correct the condition.
3. Reconstructive surgery and associated procedures, including internal breast prostheses, following a mastectomy, regardless of when the mastectomy was performed.

Members will be covered for all stages of reconstruction on the non-diseased breast to make it equivalent in size with the diseased breast.

Complications of covered mastectomy services, including lymphedemas, are covered.

Excluded: complications of noncovered surgical services.

E. Home Health Care Services. Home health care services, as set forth in this section, shall be covered when provided by and referred in advance by a GHC Provider for Members who meet the following criteria:

1. The Member is unable to leave home due to his/her health problem or illness. Unwillingness to travel and/or arrange for transportation does not constitute inability to leave the home.
2. The Member requires intermittent skilled home health care services, as described below.
3. A GHC Provider has determined that such services are Medically Necessary and are most appropriately rendered in the Member's home.

For the purposes of this section, "skilled home health care" means reasonable and necessary care for the treatment of an illness or injury which requires the skill of a nurse or therapist, based on the complexity of the service and the condition of the patient and which is performed directly by an appropriately licensed professional provider.

Covered Services for home health care may include the following when rendered pursuant to an approved home health care plan of treatment: nursing care, physical therapy, occupational therapy, respiratory therapy, restorative speech therapy and medical social worker and limited home health aide services. Home health services are covered on an intermittent basis in the Member's home. "Intermittent" means care that is to be rendered because of a medically predictable recurring need for skilled home health care services.

Excluded: custodial care and maintenance care, private duty or continuous nursing care in the Member's home, housekeeping or meal services, care in any nursing home or convalescent facility, any care provided by or for a member of the patient's family and any other services rendered in the home which do not meet the definition of skilled home health care above or are not specifically listed as covered under the Agreement.

F. Hospice Care. Hospice care is covered in lieu of curative treatment for terminal illness for Members who meet all of the following criteria:

- A GHC Provider has determined that the Member's illness is terminal and life expectancy is six (6) months or less.
- The Member has chosen a palliative treatment focus (emphasizing comfort and supportive services rather than treatment aimed at curing the Member's terminal illness).
- The Member has elected in writing to receive hospice care through GHC's Hospice Program or GHC's approved hospice program.
- The Member has available a primary care person who will be responsible for the Member's home care.
- A GHC Provider and GHC's Hospice Director, or his/her designee, have determined that the Member's illness can be appropriately managed in the home.

Hospice care shall mean a coordinated program of palliative and supportive care for dying Members by an interdisciplinary team of professionals and volunteers centering primarily in the Member's home.

1. Covered Services. Care may include the following as prescribed by a GHC Provider and rendered pursuant to an approved hospice plan of treatment:

a. Home Services

- i. Intermittent care by a hospice interdisciplinary team which may include services by a physician, nurse, medical social worker, physical therapist, speech therapist, occupational therapist, respiratory therapist, limited services by a Home Health Aide under the supervision of a Registered Nurse and homemaker services.
- ii. Continuous care services in the Member's home when prescribed by a GHC Provider, as set forth in this paragraph. "Continuous care" means skilled nursing care provided in the home during a period of crisis in order to maintain the terminally ill Member at home. Continuous care may be provided for pain or symptom management by a Registered Nurse, Licensed Practical Nurse or Home Health Aide under the supervision of a Registered Nurse. Continuous care is covered up to twenty-four (24) hours per day during periods of crisis. Continuous care is covered only when a GHC Provider determines that the Member would otherwise require hospitalization in an acute care facility.

b. Inpatient Hospice Services. For short-term care, inpatient hospice services shall be covered in a facility designated by GHC's Hospice Program or GHC-approved hospice program when authorized in advance by a GHC Provider and GHC's Hospice Program or GHC-approved hospice program.

Inpatient respite care is covered for a maximum of five (5) consecutive days per occurrence in order to continue care for the Member in the temporary absence of the Member's primary care giver(s).

c. Other covered hospice services may include the following:

- i. Drugs and biologicals that are used primarily for the relief of pain and symptom management.
- ii. Medical appliances and supplies primarily for the relief of pain and symptom management.
- iii. Counseling services for the Member and his/her primary care-giver(s).
- iv. Bereavement counseling services for the family.

2. Hospice Exclusions. All services not specifically listed as covered in this section are excluded, including:

- a. Financial or legal counseling services.
- b. Meal services.
- c. Custodial or maintenance care in the home or on an inpatient basis, except as provided above.
- d. Services not specifically listed as covered by the Agreement.
- e. Any services provided by members of the patient's family.

- f. All other exclusions listed in Section V., General Exclusions, apply.

G. Rehabilitation Services.

1. Rehabilitation services are covered as set forth in this section, limited to the following: physical therapy; occupational therapy; and speech therapy to restore function following illness, injury or surgery. Services are subject to all terms, conditions and limitations of the Agreement, including the following:
 - a. All services must be provided at a GHC or GHC-approved rehabilitation facility and must be prescribed and provided by a GHC-approved rehabilitation team that may include medical, nursing, physical therapy, occupational therapy, massage therapy and speech therapy providers.
 - b. Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness or surgery. Such services are provided only when GHC's Medical Director, or his/her designee, determines that significant, measurable improvement to the Member's condition can be expected within a sixty (60) day period as a consequence of intervention by covered therapy services described in paragraph a., above.
 - c. Coverage for inpatient and outpatient services is limited to the Allowance set forth in the Allowances Schedule.

Excluded: specialty rehabilitation programs not provided by GHC; long-term rehabilitation programs; physical therapy, occupational therapy and speech therapy services when such services are available (whether application is made or not) through programs offered by public school districts; therapy for degenerative or static conditions when the expected outcome is primarily to maintain the Member's level of functioning (except as set forth in subsection 2. below); recreational, life-enhancing, relaxation or palliative therapy; implementation of home maintenance programs; programs for treatment of learning problems; any services not specifically included as covered in this section; and any services that are excluded under Section V.

2. **Neurodevelopmental Therapies for Children Age Six (6) and Under.** Physical therapy, occupational therapy and speech therapy services for the restoration and improvement of function for neurodevelopmentally disabled children age six (6) and under shall be covered. Coverage includes maintenance of a covered Member in cases where significant deterioration in the Member's condition would result without the services. Coverage for inpatient and outpatient services is limited to the Allowance set forth in the Allowances Schedule.

Excluded: specialty rehabilitation programs not provided by GHC; long-term rehabilitation programs; physical therapy, occupational therapy and speech therapy services when such services are available (whether application is made or not) through programs offered by public school districts; recreational, life-enhancing, relaxation or palliative therapy; implementation of home maintenance programs; programs for treatment of learning problems; any services not specifically included as covered in this section; and any services that are excluded under Section V.

H. Devices, Equipment and Supplies.

Devices, equipment and supplies, which restore or replace functions that are common and necessary to perform basic activities of daily living, are covered as set forth in the Allowances Schedule. Examples of basic activities of daily living are dressing and feeding oneself, maintaining personal hygiene, lifting and gripping in order to prepare meals and carrying groceries.

1. **Orthopedic Appliances.** Orthopedic appliances, which are attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration or improvement of its function.

Excluded: arch supports, including custom shoe modifications or inserts and their fittings except for therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease; and orthopedic shoes that are not attached to an appliance.

2. **Ostomy Supplies.** Ostomy supplies for the removal of bodily secretions or waste through an artificial opening.
3. **Durable Medical Equipment.** Durable medical equipment is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and used in the Member's home. Durable medical equipment includes: hospital beds, wheelchairs, walkers, crutches,

canes, glucose monitors, external insulin pumps, oxygen and oxygen equipment. GHC, in its sole discretion, will determine if equipment is made available on a rental or purchase basis.

4. Prosthetic Devices. Prosthetic devices are items which replace all or part of an external body part, or function thereof.

When authorized in advance, repair, adjustment or replacement of appliances and equipment is covered.

Excluded: items which are not necessary to restore or replace functions of basic activities of daily living; and replacement or repair of appliances, devices and supplies due to loss, breakage from willful damage, neglect or wrongful use, or due to personal preference.

I. Tobacco Cessation. When provided through GHC, services related to tobacco cessation are covered, limited to:

1. Participation in one individual or group program per calendar year;
2. Educational materials; and
3. One course of nicotine replacement therapy per calendar year, provided the Member is actively participating in a GHC-designated tobacco cessation program.

J. Drugs, Medicines, Supplies and Devices. *This benefit, for purposes of creditable coverage, is actuarially equal to or greater than the Medicare Part D prescription drug benefit. Eligible Members who are also eligible for Medicare Part D pharmacy benefits can remain covered under the Agreement and not be subject to Medicare-imposed late enrollment penalties should they decide to enroll in a Medicare Part D pharmacy plan at a later date.*

The Agreement may include Medicare Part D pharmacy benefits as part of the GHC Medicare Advantage Plan required for Medicare eligible Members who live in the GHC Medicare Advantage Service Area. See Section III.D. for more information.

A Member who discontinues coverage under the Agreement must meet eligibility requirements in order to re-enroll.

Legend medications are drugs which have been approved by the Food and Drug Administration (FDA) and which can, under federal or state law, be dispensed only pursuant to a prescription order. These drugs, including off-label use of FDA-approved drugs (provided that such use is documented to be effective in one of the standard reference compendia; a majority of well-designed clinical trials published in peer-reviewed medical literature document improved efficacy or safety of the agent over standard therapies, or over placebo if no standard therapies exist; or by the federal secretary of Health and Human Services), contraceptive drugs and devices and their fitting, diabetic supplies, including insulin syringes, lancets, urine-testing reagents, blood-glucose monitoring reagents and insulin, are covered as set forth below.

All drugs, supplies, medicines and devices must be prescribed by a GHC Provider for conditions covered by the Agreement, obtained at a GHC pharmacy and, unless approved by GHC in advance, be listed in the GHC drug formulary. The prescription drug **Cost Share**, as set forth in the Allowances Schedule, applies to each thirty (30) day supply. **Cost Shares** for single and multiple thirty (30) day supplies of a given prescription are payable at the time of delivery. Injectables that can be self-administered are also subject to the prescription drug **Cost Share**. Drug formulary (approved drug list) is defined as a list of preferred pharmaceutical products, supplies and devices developed and maintained by GHC.

Generic drugs will be dispensed whenever available. Brand name drugs will be dispensed if there is not a generic equivalent. In the event the Member elects to purchase brand-name drugs instead of the generic equivalent (if available), or if the Member elects to purchase a different brand-name or generic drug than that prescribed by the Member's Provider, and it is not determined to be Medically Necessary, the Member will also be subject to payment of the additional amount above the applicable pharmacy Cost Share set forth in the Allowances Schedule. A generic drug is defined as a drug that is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug. A brand name drug is defined as a prescription drug that has been patented and is only available through one manufacturer.

"Standard reference compendia" means the American Hospital Formulary Service-Drug Information; the American Medical Association Drug Evaluation; the United States Pharmacopoeia-Drug Information, or other authoritative

compendia as identified from time to time by the federal secretary of Health and Human Services. “Peer-reviewed medical literature” means scientific studies printed in healthcare journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

Excluded: over-the-counter drugs, medicines, supplies and devices not requiring a prescription under state law or regulations; drugs used in the treatment of sexual dysfunction disorders; medicines and injections for anticipated illness while traveling; vitamins, including Legend (prescription) vitamins; and any other drugs, medicines and injections not listed as covered in the GHC drug formulary unless approved in advance by GHC as Medically Necessary.

The Member will be charged for replacing lost or stolen drugs, medicines or devices.

The Member’s Right to Safe and Effective Pharmacy Services.

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee Members’ right to know what drugs are covered under the Agreement and what coverage limitations are in the Agreement. Members who would like more information about the drug coverage policies under the Agreement, or have a question or concern about their pharmacy benefit, may contact **GHC** at (206) 901-4636 or (888) 901-4636.

Members who would like to know more about their rights under the law, or think any services received while enrolled may not conform to the terms of the Agreement, may contact the Washington State Office of Insurance Commissioner at (800) 562-6900. Members who have a concern about the pharmacists or pharmacies serving them, may call the State Department of Health at (360) 236-4825.

- K. Mental Health Care Services.** GHC and Washington State law have established standards to assure the competence and professional conduct of mental health service providers, to guarantee Members’ rights to informed consent to treatment, to assure the privacy of their medical information, to enable Members to know which services are covered under the Agreement and to know the limitations on their coverage. Members who would like a more detailed description than is provided here of covered benefits for mental health services under the Agreement, or have questions or concerns about any aspect of their mental health benefits, may contact GHC at (888) 901-4636.

Members who would like to know more about their rights under the law, or think any services received while enrolled may not conform to the terms of the Agreement or their rights under the law, may contact the Washington State Office of the Insurance Commissioner at (800) 562-6900. Members who have a concern about the qualifications or professional conduct of their mental health provider may call the *Washington State Department of Health at 1 (800) 525-0127*.

Services that are provided by a mental health practitioner will be covered as mental health care, regardless of the cause of the disorder.

- 1. Outpatient Services.** Outpatient mental health services place priority on restoring the Member to his/her level of functioning prior to the onset of acute symptoms or to achieve a clinically appropriate level of stability as determined by GHC’s Medical Director, or his/her designee. Treatment for clinical conditions may utilize psychiatric, psychological and/or psychotherapy services to achieve these objectives.

Coverage for each Member is provided according to the outpatient mental health care Allowance set forth in the Allowances Schedule. Psychiatric medical services, including medical management and prescriptions, are covered as set forth in Sections IV.B. and IV.J.

- 2. Inpatient Services.** Charges for services described in this section, including psychiatric Emergencies resulting in inpatient services, shall be covered up to the maximum benefit set forth in the Allowances Schedule. This benefit shall include coverage for acute treatment and stabilization of psychiatric Emergencies in GHC-approved hospitals. When medically indicated, outpatient electro-convulsive therapy (ECT) is covered in lieu of inpatient services. Coverage for services incurred at non-GHC Facilities shall exclude any charges that would otherwise be excluded for hospitalization within a GHC Facility.

Partial hospitalization is covered subject to the maximum inpatient benefit limit described in the Allowances Schedule. Every two (2) partial hospitalization days are equivalent to one inpatient hospital day. The total maximum

annual benefit under this section shall not exceed the number of inpatient days described in the Allowances Schedule.

Subject to the maximum inpatient mental health care Allowance set forth in the Allowances Schedule, services provided under involuntary commitment statutes shall be covered at facilities approved by GHC. Services for any involuntary court-ordered treatment program beyond seventy-two (72) hours shall be covered only if determined to be Medically Necessary by GHC's Medical Director, or his/her designee.

Coverage for voluntary/involuntary Emergency inpatient psychiatric services is subject to the Emergency care benefit set forth in Section IV.L., including the twenty-four (24) hour notification and transfer provisions.

Outpatient electro-convulsive therapy treatment is covered subject to the outpatient surgery Cost Share.

3. **Exclusions and Limitations for Outpatient and Inpatient Mental Health Treatment Services.** Covered Services are limited to those *authorized by GHC's Medical Director, or his/her designee*, for covered clinical conditions for which the reduction or removal of acute clinical symptoms or stabilization can be expected *given the most clinically appropriate level of mental health care intervention*.

Partial hospitalization programs are covered only under subsection K.2. (Inpatient Services).

Excluded: treatment specific to and solely for personality disorders; learning, communication and motor skills disorders; mental retardation; academic or career counseling; sexual and identity disorders; and personal growth or relationship enhancement. Also excluded: assessment and treatment services that are primarily vocational and academic; court-ordered or forensic treatment, including reports and summaries, not considered Medically Necessary; written information other than clinical records; work or school ordered assessment and treatment not considered Medically Necessary; counseling for overeating; psychoanalysis; nicotine related disorders; treatment or consultations provided by telephone; relationship counseling or phase of life problems (V code only diagnoses); all forms of day treatment (non-partial hospital programs); custodial care; and specialty programs for mental health therapy not specifically authorized by Behavioral Health Services and approved by GHC.

Any other services not specifically listed as covered in this section. All other provisions, exclusions and limitations under the Agreement also apply.

L. Emergency/Urgent Care.

All services are covered subject to the Cost Shares set forth in the Allowances Schedule.

Emergency Care (See Section VIII. for a definition of Emergency.)

1. **At a GHC Facility.** GHC will cover Emergency care for all Covered Services.
2. **At a Non-GHC Facility.** Usual, Customary and Reasonable charges for Emergency care for Covered Services are covered subject to:
 - a. Payment of the Emergency care Deductible; and
 - b. Notification of GHC by way of the GHC Notification Line within twenty-four (24) hours following inpatient admission, or as soon thereafter as medically possible.
3. **Waiver of Emergency Care Cost Share.**
 - a. **Waiver for Multiple Injury Accident.** If two or more Members in the same Family Unit require Emergency care as a result of the same accident, coverage for all Members will be subject to only one (1) Emergency care Cost Share.
 - b. **Emergencies Resulting in an Inpatient Admission.** If the Member is admitted to a GHC Facility directly from the emergency room, the Emergency care Copayment is waived. However, coverage will be subject to the inpatient services Cost Share.

- 4. Transfer and Follow-up Care.** If a Member is hospitalized in a non-GHC Facility, GHC reserves the right to require transfer of the Member to a GHC Facility, upon consultation between a GHC Provider and the attending physician. If the Member refuses to transfer to a GHC Facility, all further costs incurred during the hospitalization are the responsibility of the Member.

Follow-up care which is a direct result of the Emergency must be obtained from GHC Providers, unless a GHC Provider has authorized such follow-up care from a non-GHC Provider in advance.

Urgent Care (See Section VIII. for a definition of Urgent Condition.)

Inside the GHC Service Area, care for Urgent Conditions is covered only at GHC medical centers, GHC urgent care clinics or GHC Providers' offices, subject to the applicable Cost Share. Urgent care received at any hospital emergency department is not covered unless authorized in advance by a GHC Provider.

Outside the GHC Service Area, Usual, Customary and Reasonable charges are covered for Urgent Conditions received at any medical facility, subject to the applicable Cost Share.

- M. Ambulance Services.** Ambulance services are covered as set forth below, provided that the service is authorized in advance by a GHC Provider or meets the definition of an Emergency (see Section VIII.).

- 1. Emergency Transport to any Facility.** Each Emergency is covered as set forth in the Allowances Schedule.
- 2. Interfacility Transfers.** GHC-initiated non-emergent transfers to or from a GHC Facility are covered as set forth in the Allowances Schedule.

- N. Skilled Nursing Facility (SNF).** Skilled nursing care in a GHC-approved skilled nursing facility when full-time skilled nursing care is necessary in the opinion of the attending GHC Provider, is covered as set forth in the Allowances Schedule.

When prescribed by a GHC Provider, such care may include room and board; general nursing care; drugs, biologicals, supplies and equipment ordinarily provided or arranged by a skilled nursing facility; and short-term physical therapy, occupational therapy and restorative speech therapy.

Excluded: personal comfort items such as telephone and television, rest cures and custodial, domiciliary or convalescent care.

Section V. General Exclusions

In addition to exclusions listed throughout the Agreement, the following are not covered:

1. Services or supplies not specifically listed as covered in the Schedule of Benefits, Section IV.
2. Except as specifically listed and identified as covered in Sections IV.B., IV.D., IV.H. and IV.J., corrective appliances and artificial aids including: eyeglasses; contact lenses and services related to their fitting; hearing devices and hearing aids, including related examinations; take-home drugs, dressings and supplies following hospitalization; and any other supplies, dressings, appliances, devices or services which are not specifically listed as covered in Section IV.
3. Cosmetic services, including treatment for complications resulting from cosmetic surgery, except as provided in Section IV.D.
4. Convalescent or custodial care.
5. Durable medical equipment such as hospital beds, wheelchairs and walk-aids, except while in the hospital or as set forth in Section IV.B., IV.E., IV.F. or IV.H.
6. Services rendered as a result of work-related injuries, illnesses or conditions, including injuries, illnesses or conditions incurred as a result of self-employment.

7. Those parts of an examination and associated reports and immunizations required for employment, unless otherwise noted in Section IV.B., immigration, license, travel or insurance purposes that are not deemed Medically Necessary by GHC for early detection of disease.
8. Services and supplies related to sexual reassignment surgery, such as sex change operations or transformations and procedures or treatments designed to alter physical characteristics.
9. Diagnostic testing and medical treatment of sterility, infertility and sexual dysfunction, regardless of origin or cause, unless otherwise noted in Section IV.B.
10. Any services to the extent benefits are available to the Member under the terms of any vehicle, homeowner's, property or other insurance policy, except for individual or group health insurance, whether the Member asserts a claim or not, pursuant to: (a) medical coverage, medical "no fault" coverage, Personal Injury Protection coverage or similar medical coverage contained in said policy; and/or (b) uninsured motorist or underinsured motorist coverage contained in said policy. For the purpose of this exclusion, benefits shall be deemed to be "available" to the Member if the Member is a named insured, comes within the policy definition of insured, is a third-party donee beneficiary under the terms of the policy or otherwise has the right to receive benefits under the policy.

The Member and his/her agents must cooperate fully with GHC in its efforts to enforce this exclusion. This cooperation shall include supplying GHC with information about any available insurance coverage. The Member and his/her agents shall permit GHC, at GHC's option, to associate with the Member or to intervene in any action filed against any party related to the injury. The Member and his/her agents shall do nothing to prejudice GHC's right to enforce this exclusion. In the event the Member fails to cooperate fully, the Member shall be responsible for reimbursing GHC for such medical expenses.

GHC shall not enforce this exclusion as to coverage available under uninsured motorist or underinsured motorist coverage until the Member has been made whole, unless the Member fails to cooperate fully with GHC as described above.

GHC shall not pay any attorneys' fees or collection costs to attorneys representing the injured person where it has retained its own legal counsel or acts on its own behalf to represent its interests and unless there is a written fee agreement signed by GHC prior to any collection efforts. Under no circumstances will GHC pay legal fees for services which were not reasonably and necessarily incurred to secure recovery and/or which do not benefit GHC. If it becomes necessary for GHC to enforce the provisions of this section by initiating any action against the injured person or his/her agent, then the injured person agrees to pay GHC's attorneys' fees and costs associated with the action.

11. Voluntary (not medically indicated and nontherapeutic) termination of pregnancy, unless otherwise noted in Section IV.B.
12. The cost of services and supplies resulting from a Member's loss of or willful damage to appliances, devices, supplies and materials covered by GHC for the treatment of disease, injury or illness.
13. Orthoptic therapy (i.e., eye training).
14. Specialty treatment programs such as weight reduction, "behavior modification programs" and rehabilitation, including cardiac rehabilitation.
15. Services required as a result of war, whether declared or undeclared. Care needed for injuries or conditions resulting from active or reserve military service.
16. Nontherapeutic sterilization, unless otherwise noted in Section IV.B., and procedures and services to reverse a therapeutic or nontherapeutic sterilization.
17. Dental care, surgery, services and appliances, including: treatment of accidental injury to natural teeth, reconstructive surgery to the jaw in preparation for dental implants, dental implants, periodontal surgery and any other dental services not specifically listed as covered in Section IV. GHC's Medical Director, or his/her designee, will determine whether the care or treatment required is within the category of dental care or service.

18. Drugs, medicines and injections, except as set forth in Section IV.J. Any exclusion of drugs, medicines and injections, including those not listed as covered in the GHC drug formulary (approved drug list), will also exclude their administration.
19. Experimental or investigational services.

GHC consults with GHC's Medical Director and then uses the criteria described below to decide if a particular service is experimental or investigational.

- a. A service is considered experimental or investigational for a Member's condition if any of the following statements apply to it at the time the service is or will be provided to the Member.
 - i. The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted.
 - ii. The service is the subject of a current new drug or new device application on file with the FDA.
 - iii. The service is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity or efficacy of the service.
 - iv. The service is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity or efficacy as among its objectives.
 - v. The service is under continued scientific testing and research concerning the safety, toxicity or efficacy of services.
 - vi. The service is provided pursuant to informed consent documents that describe the service as experimental or investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity or efficacy.
 - vii. The prevailing opinion among experts, as expressed in the published authoritative medical or scientific literature, is that (1) the use of such service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity or efficacy of the service.
- b. In making determinations whether a service is experimental or investigational, the following sources of information will be relied upon exclusively:
 - i. The Member's medical records,
 - ii. The written protocol(s) or other document(s) pursuant to which the service has been or will be provided,
 - iii. Any consent document(s) the Member or Member's representative has executed or will be asked to execute, to receive the service,
 - iv. The files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,
 - v. The published authoritative medical or scientific literature regarding the service, as applied to the Member's illness or injury, and
 - vi. Regulations, records, applications and any other documents or actions issued by, filed with or taken by, the FDA or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

Appeals regarding denial of coverage can be submitted to the Member **Appeals** Department, or to GHC's **Medical Director at** P.O. Box 34593, Seattle, WA 98124-1593. GHC will respond in writing within twenty (20) working days of the receipt of a fully documented appeal request. An expedited appeal is available if a delay would jeopardize the Member's life or health.

20. Mental health care, except as specifically provided in Section IV.K.
21. Hypnotherapy, and all services related to hypnotherapy.
22. Genetic testing and related services, unless determined Medically Necessary by GHC's Medical Director, or his/her designee, and in accordance with Board of Health standards for screening and diagnostic tests, or specifically provided in Section IV.B. Testing for non-Members is also excluded.

23. Follow-up visits related to a non-Covered Service.
24. Fetal ultrasound in the absence of medical indications.
25. Routine foot care, except in the presence of a non-related Medical Condition affecting the lower limbs.
26. Complications of non-Covered Services.
27. Treatment of obesity, except as set forth in Section IV.B.
28. Services or supplies for which no charge is made, or for which a charge would not have been made if the Member had no health care coverage or for which the Member is not liable; services provided by a member of the Member's family.
29. Autopsy and associated expenses.
30. Services provided by government agencies, except as required by federal or state law.
31. Services related to temporomandibular joint disorder (TMJ) and/or associated facial pain or to correct congenital conditions, including bite blocks and occlusal equilibration, except as specified as covered in Section IV.B.
32. Services covered by the national health plan of any other country.
33. Pre-Existing Conditions, except as specifically provided in Section IV.B.26.

Section VI. Grievance Processes for Complaints and Appeals

The grievance processes to express a complaint and appeal a denial of benefits are set forth below.

Filing a Complaint or Appeal

The complaint process is available for a Member to express dissatisfaction about customer service or the quality or availability of a health service.

The appeals process is available for a Member to seek reconsideration of a denial of benefits.

Complaint Process

Step 1: The Member should contact the person involved, explain his/her concerns and what he/she would like to have done to resolve the problem. The Member should be specific and make his/her position clear.

Step 2: If the Member is not satisfied, or if he/she prefers not to talk with the person involved, the Member should call the department head or the manager of the medical center or department where he/she is having a problem. That person will investigate the Member's concerns. Most concerns can be resolved in this way.

Step 3: If the Member is still not satisfied, he/she should call the GHC Customer Service Center toll free at (888) 901-4636. Most concerns are handled by phone within a few days. In some cases the Member will be asked to write down his/her concerns and state what he/she thinks would be a fair resolution to the problem. A Customer Service Representative or Service Quality Coordinator will investigate the Member's concern by consulting with involved staff and their supervisors, and reviewing pertinent records, relevant plan policies and the Member Rights and Responsibilities statement. This process can take up to thirty (30) days to resolve after receipt of the Member's written statement.

If the Member is dissatisfied with the resolution of the complaint, he/she may contact the Service Quality Coordinator or the Customer Service Center.

Appeals Process

Step 1: If the Member wishes to appeal a decision denying benefits, he/she must submit a request for an appeal either orally or in writing to the **Member** Appeals Department, specifying why he/she disagrees with the decision. The appeal must be

submitted within 180 days of the denial notice he/she received. If the Member is located west of the Cascade Mountains, appeals should be directed to GHC's **Member** Appeals Department, P.O. Box 34593, Seattle, WA 98124-1593, (206) 901-7350 or toll free (888) 901-4636; or if the Member is located east of the Cascade Mountains, to GHC's **Member** Appeals Department, P.O. Box 204, Spokane, WA 99210-0204, (509) 838-9100 or toll free (800) 497-2210.

An Appeals Coordinator will review initial appeal requests. GHC will then notify the Member of its determination or need for an extension of time within fourteen (14) days of receiving the request for appeal. Under no circumstances will the review timeframe exceed thirty (30) days without the Member's written permission.

If the appeal request is for an experimental or investigational exclusion or limitation, GHC will make a determination and notify the Member in writing within twenty (20) working days of receipt of a fully documented request. In the event that additional time is required to make a determination, GHC will notify the Member in writing that an extension in the review timeframe is necessary. Under no circumstances will the review timeframe exceed twenty (20) days without the Member's written permission.

There is an expedited appeals process in place for cases which meet criteria or where the Member's doctor states clinical urgency exists. If a delay would jeopardize the Member's life, or materially jeopardize the Member's health, the Member can request an expedited appeal in writing to the above address, or by calling GHC's **Member** Appeals Department in western Washington at (206) 901-7350 or toll free (888) 901-4636, or in eastern Washington at (509) 838-9100 or toll free (800) 497-2210. The Member's request for an expedited appeal will be processed and a decision issued no later than seventy-two (72) hours after receipt.

If GHC fails to grant or reject the Member's request within the applicable required timeframe, the Member may proceed as if the complaint has been rejected.

Step 2: (Optional step) If the Member is not satisfied with the decision reached by the Appeals Coordinator regarding a denial of benefits, he/she may request a hearing by the appeals committee by submitting a request within thirty (30) days of the date of the decision letter. If the Member is located west of the Cascade Mountains, the request can be mailed to GHC's **Member** Appeals Department, P.O. Box 34593, Seattle, WA 98124-1593, or if the Member is located east of the Cascade Mountains, to GHC's **Member** Appeals Department, P.O. Box 204, Spokane, WA 99210-0204.*

The appeals committee is the final review authority within GHC and its decisions are final. The Member is encouraged to present his/her case to the appeals committee in person. The hearing, and written notification to the Member of the appeals committee decision, will be made within thirty (30) working days of the Member's request. As an alternative to this appeal step, the Member may proceed to Step 3 below.

Step 3: If the Member is not satisfied with the decision made in Step 1 or Step 2 above, or if GHC exceeds the timeframes stated in Step 1 or Step 2 above without good cause and without reaching a decision, a final level of appeal is available through an independent review organization. An independent review organization is not legally affiliated or controlled by GHC. Once a decision is made through an independent review, the decision is final and cannot be appealed through GHC. *

* If the Member's health plan is governed by the Employee Retirement Income Security Act, known as "ERISA" (most employment related health plans, other than those sponsored by governmental entities or churches – ask employer about plan), the Member has the right to file a lawsuit under Section 502(a) of ERISA to recover benefits due to the Member under the plan at any point after completion of Step 1 of the appeals process. Members may have other legal rights and remedies available under state or federal law.

Section VII. General Provisions

A. Coordination of Benefits

- 1. Benefits Subject to This Provision.** As described in subsection 6. below, all benefits provided under the Agreement are subject to the provisions listed in this section.
- 2. Definitions.**
 - a. Plan.** The definition of a "plan" includes the following sources of benefits or services:

- i. Individual, group or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements, issued by insurers, health care service contractors and health maintenance organizations;
- ii. Labor-management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans;
- iii. Governmental programs; and
- iv. Coverage required or provided by any statute.

The term "plan" shall be construed separately with respect to each policy, agreement or other arrangement for benefits or services, and separately with respect to the respective portions of any such policy, agreement or other arrangement which do and which do not reserve the right to take the benefits or services of other policies, agreements or other arrangements into consideration in determining benefits.

- b. **Allowable Expense.** "Allowable expense" means any *Usual, Customary and Reasonable* items of expense at least a portion of which is covered under at least one of the plans covering the person for whom the claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be considered an allowable expense.
 - c. **Claim Determination Period.** "Claim determination period" means a calendar year, except the Member's first claim determination period shall begin on the Member's effective date of coverage under the Agreement and end on December 31 of that same calendar year. In no event will a claim determination period for any Member extend beyond the last day the Member is covered under the Agreement.
3. **Right to Receive and Release Information.** For the purpose of determining the applicability of and implementing this provision and any provision of similar purpose in any other plan, GHC may, with any consent necessary, release to or obtain from any other insurer, organization or person any information, regarding any person which GHC considers necessary for such purpose. Any Member claiming benefits under the Agreement shall provide GHC with the information necessary for such purpose.
 4. **Facility of Payment.** Whenever coverage has been provided or paid for under any other plan which should have been provided under the Agreement in accordance with this provision, GHC shall have the right, exercisable alone and in its sole discretion, to pay over to any plan making such payments any amounts GHC shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be considered as coverage or benefits paid under the Agreement and, to the extent of such payments, GHC shall be fully discharged from liability under the Agreement.
 5. **Right of Recovery.** Whenever benefits have been provided by GHC with respect to allowable expenses in total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, GHC shall have the right to recover the reasonable cash value of such benefits, to the extent of such excess, from one or more of the following, as GHC shall determine: any persons to or for or with respect to whom such benefits were provided, any other insurers, service plans, other organizations or other plans.
 6. **Effect on Benefits.**
 - a. This provision shall apply in determining the benefits for a Member covered under the Agreement for a particular claim determination period if, for the allowable expenses incurred by the Member during such period, the sum of:
 - i. The reasonable cash value of the benefits that would be provided under the Agreement in the absence of this provision, and
 - ii. The benefits that would be payable under all other plans in the absence therein or provisions of similar purpose to this provision would exceed such allowable expenses.
 - b. As to any claim determination period with respect to which this provision is applicable, the reasonable cash value of the benefits provided under the Agreement in the absence of this provision for the allowable expenses

incurred as to such person during such claim determination period shall be reduced to the extent necessary so that the sum of the reasonable cash value of benefits and all benefits payable for such allowable expenses under all other plans, except as provided in subparagraph c. of this section, shall not exceed the total of such allowable expenses. Benefits payable under another plan include benefits that would have been payable had a claim been duly made therefor. In determining liability under this paragraph, GHC is not required, and will not take into consideration, Deductibles, Copayments or other Cost Share provisions.

- c. If another plan which is involved in subparagraph b. of this section and which contains a provision coordinating its benefits with those of the Agreement would, according to its rules, determine its benefits after the benefits of this plan have been determined; and the rules set forth in subparagraph d. of this section would require the Agreement to determine its benefits before such other plan, then the benefits of such other plan will be ignored for the purposes of determining the benefits under the Agreement.
- d. For the purposes of subparagraph c. of this section, the rules establishing the order of benefit determination are:
 - i. The benefits of a plan which covers the person on whose expenses a claim is based as a Subscriber shall be determined before the benefits of a plan which covers such person as a Dependent.
 - ii. If a Dependent is covered under both parents' medical plans, the benefits of the plan of the parent whose birthday, excluding year, falls earlier in the calendar year are determined before those of the plan of a parent whose birthday, excluding year, falls later in the calendar year.
 - a) When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a Dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a Dependent of the parent without custody; and
 - b) When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a Dependent of the stepparent, and the benefits of a plan which covers that child as a Dependent of the stepparent will be determined before the benefits of a plan which covers that child as a Dependent of the parent without custody.

Notwithstanding items a) and b) above, if there is a court decree which would otherwise establish financial responsibility for the health care expenses of the child, the benefits of a plan which covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a Dependent.

- iii. When rules i. and ii. do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time, provided that:
 - a) The benefits of a plan covering the person as a laid-off or retired employee, or Dependent of such person shall be determined after the benefits of any other plan covering such person as an employee, other than a laid-off or retired employee, or Dependent of such person; and
 - b) If either plan does not have a provision regarding laid off or retired employees, which results in each plan determining its benefits after the other, then the provisions of a) of this subsection shall not apply.
- iv. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, Member or Subscriber for the longer period of time shall be determined before those of the plan which covered that person for the shorter time period.
- e. When this provision operates to reduce the total amount of benefits otherwise to be provided to a person covered under the Agreement during any claim determination period, the reasonable cash value of each benefit that would be provided in the absence of this provision shall be reduced proportionately and such reduced amount shall be charged against any applicable benefit limit of the Agreement.

7. Effect of Medicare.

Members Residing Outside the GHC Medicare Advantage Service Area. If a Member is or becomes eligible for Medicare coverage and Medicare is determined to be the primary bill payer, the Member must enroll in, and maintain both Medicare Part A and Part B coverage in order to be eligible for continuing coverage under the Agreement.

Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status.

When GHC renders care to a Member who is eligible for Medicare benefits, and Medicare is deemed to be the primary bill payer under Medicare primary/secondary payer guidelines and regulations, GHC will seek Medicare reimbursement for all Medicare covered services.

B. Subrogation and Reimbursement Rights

“Injured Person” under this section means a Member covered by the Agreement who sustains an injury and any spouse, dependent or other person or entity that may recover on behalf of such Member, including the estate of the Member and, if the Member is a minor, the guardian or parent of the Member. When referred to in this section, “GHC’s Medical Expenses” means the expense incurred and the reasonable value of the services provided by GHC for the care or treatment of the injury sustained by the Injured Person.

If the Injured Person’s injuries were caused by a third party giving rise to a claim of legal liability against the third party and/or payment by the third party to the Injured Person and/or a settlement between the third party and the Injured Person, GHC shall have the right to recover GHC’s Medical Expenses from any source available to the Injured Person as a result of the events causing the injury, including but not limited to funds available through applicable third party liability coverage and uninsured/underinsured motorist coverage. This right is commonly referred to as “subrogation.” GHC shall be subrogated to and may enforce all rights of the Injured Person to the extent of GHC’s Medical Expenses.

GHC’s subrogation and reimbursement rights shall be limited to the excess of the amount required to fully compensate the Injured Person for the loss sustained, including general damages. However, in the case of Medicare Advantage Members, GHC’s right of subrogation shall be the full amount of GHC’s Medical Expenses and is limited only as required by Medicare.

If the Injured Person is entitled to or does receive money from any source as a result of the events causing the injury, including but not limited to any party’s liability insurance or uninsured/underinsured motorist funds, then GHC’s Medical Expenses provided or to be provided to the Injured Person are secondary, not primary, and will be paid only if the Injured Person fully cooperates with the terms and conditions of the Agreement. As a condition of receiving benefits under the Agreement, the Injured Person agrees that acceptance of GHC services is constructive notice of this provision in its entirety and agrees to reimburse GHC for the benefits the Injured Person received as a result of the events causing the injury.

The Injured Person and his/her agents shall cooperate fully with GHC in its efforts to collect GHC’s Medical Expenses. This cooperation includes, but is not limited to, supplying GHC with information about any third parties, defendants and/or insurers related to the Injured Person’s claim and informing GHC of any settlement or other payments relating to the Injured Person’s injury. The Injured Person and his/her agents shall permit GHC, at GHC’s option, to associate with the Injured Person or to intervene in any legal, quasi-legal, agency or any other action or claim filed. If the Injured Person takes no action to recover money from any source, then the Injured Person agrees to allow GHC to initiate its own direct action for reimbursement or subrogation, including, but not limited to, billing the Injured Person directly for GHC’s Medical Expenses.

The Injured Person and his/her agents shall do nothing to prejudice GHC’s subrogation and reimbursement rights. The Injured Person shall promptly notify GHC of any tentative settlement with a third party and shall not settle a claim without protecting GHC’s interest. If the Injured Person fails to cooperate fully with GHC in recovery of GHC’s Medical Expenses, the Injured Person shall be responsible for directly reimbursing GHC for GHC’s Medical Expenses and GHC retains the right to bill the Injured Person directly for GHC’s Medical Expenses.

To the extent that the Injured Person recovers funds from any source, the Injured Person agrees to hold such monies in trust or in their possession until GHC’s subrogation and reimbursement rights are fully determined.

GHC shall not pay any attorney's fees or collection costs to attorneys representing the Injured Person unless there is a written fee agreement signed by GHC prior to any collection efforts. When reasonable collection costs have been incurred with GHC's prior written agreement to recover GHC's Medical Expenses, there shall be an equitable apportionment of such collection costs between GHC and the Injured Person subject to a maximum responsibility of GHC equal to one-third of the amount recovered on behalf of GHC. Under no circumstance will GHC pay legal fees for services which were not reasonably and necessarily incurred to secure recovery, which do not benefit GHC and/or where no written fee agreement has been entered into with GHC.

If it becomes necessary for GHC to enforce the provision of this section by initiating any action against the Injured Person or his/her agent, then the Injured Person agrees to pay GHC's attorney's fees and costs associated with the action.

Implementation of this section shall be deemed a part of claims administration under the Agreement and GHC shall therefore have sole discretion to interpret its terms.

C. Miscellaneous Provisions

1. **Identification Cards.** GHC will furnish cards, for identification purposes only, to all Members enrolled under the Agreement.
2. **Administration of Agreement.** GHC may adopt reasonable policies and procedures to help in the administration of the Agreement. GHC reserves the right to construe the provisions of the Agreement and to make all determinations regarding benefit entitlement and coverage.
3. **Modification of Agreement.** No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of the Agreement, convey or void any coverage, increase or reduce any benefits under the Agreement or be used in the prosecution or defense of a claim under the Agreement.
4. **Confidentiality.** GHC and the Group shall keep Member information strictly confidential and shall not disclose any information to any third party other than: (i) representatives of the receiving party (as permitted by applicable state and federal law) who have a need to know such information in order to perform the services required of such party pursuant to the Agreement, or for the proper management and administration of the receiving party, provided that such representatives are informed of the confidentiality provisions of the Agreement and agree to abide by them, (ii) pursuant to court order or (iii) to a designated public official or agency pursuant to the requirements of federal, state or local law, statute, rule or regulation.
5. **Nondiscrimination.** GHC does not discriminate on the basis of physical or mental disabilities in its employment practices and services.

Section VIII. Definitions

Agreement: The Medical Coverage Agreement between GHC and the Group.

Allowance: The maximum amount payable by GHC for certain Covered Services under the Agreement, as set forth in the Allowances Schedule.

Coinsurance: The percentage amount the Member and GHC are required to pay for Covered Services received under the Agreement. Percentages for Covered Services are set forth in the Allowances Schedule.

Contracted Network Pharmacy: A pharmacy that has contracted with GHC to provide covered legend (prescription) drugs and medicines for outpatient use under the Agreement.

Copayment: The specific dollar amount a Member is required to pay at the time of service for certain Covered Services under the Agreement, as set forth in the Allowances Schedule.

Cost Share: The portion of the cost of Covered Services the Member is liable for under the Agreement. Cost Shares for specific Covered Services are set forth in the Allowances Schedule. Cost Share includes Copayments, Coinsurances and/or Deductibles.

Covered Services: The services for which a Member is entitled to coverage under the Agreement.

Deductible: A specific amount a Member is required to pay for certain Covered Services before benefits are payable under the Agreement. The applicable Deductible amounts are set forth in the Allowances Schedule.

Dependent: Any member of a Subscriber's family who meets all applicable eligibility requirements, is enrolled hereunder and for whom the premium prescribed in the Premium Schedule has been paid.

Emergency: *The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent lay person acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily function or serious dysfunction of a bodily organ or part, or would place the Member's health in serious jeopardy.*

Family Unit: A Subscriber and all his/her Dependents.

Fee Schedule: A fee-for-service schedule adopted by GHC, setting forth the fees for medical and hospital services.

GHC-Designated Self-Referral Specialist: A GHC specialist specifically identified by GHC to whom Members may self-refer.

GHC Facility: A facility (hospital, medical center or health care center) owned, operated or otherwise designated by GHC.

GHC Medicare Plan: A plan of coverage for persons enrolled in Medicare Part A (hospital insurance) and Part B (medical insurance).

GHC Personal Physician: A provider who is employed by or contracted with GHC to provide primary care services to Members and is selected by each Member to provide or arrange for the provision of all non emergent Covered Services, except for services set forth in the Agreement which a Member can access without a Referral. Personal Physicians must be capable of and licensed to provide the majority of primary health care services required by each Member.

GHC Provider: The medical staff, clinic associate staff and allied health professionals employed by GHC, and any other health care professional or provider with whom GHC has contracted to provide health care services to Members enrolled under the Agreement, including, but not limited to physicians, podiatrists, nurses, physician assistants, social workers, optometrists, psychologists, physical therapists and other professionals engaged in the delivery of healthcare services who are licensed or certified to practice in accordance with Title 18 Revised Code of Washington.

Group: An employer, union, welfare trust or bona-fide association which has entered into a Group Medical Coverage Agreement with GHC.

Hospital Care: Those Medically Necessary services generally provided by acute general hospitals for admitted patients. Hospital Care does not include convalescent or custodial care, which can, in the opinion of the GHC Provider, be provided by a nursing home or convalescent care center.

Lifetime Maximum: The maximum value of benefits provided for Covered Services under the Agreement after which benefits under the Agreement are no longer available as set forth in the Allowances Schedule. The value of Covered Services is based on the Fee Schedule, as defined above.

Medical Condition: A disease, illness or injury.

Medically Necessary: Appropriate and clinically necessary services, as determined by GHC's Medical Director, or his/her designee, according to generally accepted principles of good medical practice, which are rendered to a Member for the diagnosis, care or treatment of a Medical Condition. Services must be medically and clinically necessary for benefits to be covered under the Agreement. The cost of services and supplies which are not Medically Necessary shall be the responsibility of the Member. In order to be Medically Necessary, services and supplies must meet the following requirements: (a) are not solely for the convenience of the Member, his/her family or the provider of the services or supplies; (b) are the most appropriate level of service or supply which can be safely provided to the Member; (c) are for the diagnosis or treatment of an actual or existing Medical Condition unless being provided under GHC's schedule for preventive services; (d) are not for recreational, life-enhancing, relaxation or palliative therapy, except for treatment of terminal conditions; (e) are appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the State of Washington, could not have been omitted without adversely affecting the Member's condition or the quality of health

services rendered; (f) as to inpatient care, could not have been provided in a provider's office, the outpatient department of a hospital or a non-residential facility without affecting the Member's condition or quality of health services rendered; (g) are not primarily for research and data accumulation; and (h) are not experimental or investigational. The length and type of the treatment program and the frequency and modality of visits covered shall be determined by GHC's Medical Director, or his/her designee.

Medicare: The federal health insurance program for the aged and disabled.

Member: Any Subscriber or Dependent enrolled under the Agreement.

Out-of-Pocket Expenses: Those Cost Shares paid by the Subscriber or Member for Covered Services, which are applied to the Out-of-Pocket Limit.

Out-of-Pocket Limit (Stop Loss): The maximum amount of Out-of-Pocket Expenses incurred and paid, during the calendar year for Covered Services received by the Subscriber and his/her Dependents within the same calendar year. The Out-of-Pocket Limit amount and Cost Shares that apply are set forth in the Allowances Schedule. Charges in excess of UCR, services in excess of any benefit level and services not covered by the Agreement are not applied to the Out-of-Pocket Limit.

Pre-Existing Condition: A condition for which there has been diagnosis, treatment (including *the use of* prescribed drugs) or medical advice within the three (3) month period prior to the effective date of coverage. The Pre-Existing Condition wait period will begin on the first day of coverage, or the first day of the enrollment waiting period if earlier.

Referral: A written temporary agreement requested in advance by a GHC Provider and approved by GHC that entitles a Member to receive Covered Services from a specified health care provider. Entitlement to such services shall not exceed the limits of the Referral and is subject to all terms and conditions of the Referral and the Agreement. Members who have a complex or serious medical or psychiatric condition may receive a standing Referral for specialist services.

Self-Referred: Covered Services received by a Member from a designated women's health care specialist or GHC-Designated Self-Referral Specialist that are not referred by a GHC Personal Physician.

Service Area: Washington counties of Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman and Yakima; Idaho counties of Kootenai and Latah; and any other areas designated by GHC.

Stop Loss: See Out-of-Pocket Limit.

Subscriber: A person employed by or belonging to the Group who meets all applicable eligibility requirements, is enrolled under the Agreement and for whom the premiums specified in the Premium Schedule have been paid.

Urgent Condition: The sudden, unexpected onset of a Medical Condition that is of sufficient severity to require medical treatment within twenty-four (24) hours of its onset.

Usual, Customary and Reasonable (UCR): A term used to define the level of benefits which are payable by GHC when expenses are incurred from a non-GHC Provider. Expenses are considered Usual, Customary and Reasonable if the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same service or supplies.

EMPLOYER GROUP PROGRAMS

GROUP MEDICARE COVERAGE



Group Health Cooperative Medicare Advantage Plan (GHMA Plan)

Following is a brief outline of the benefits available to Group Members who are also enrolled in the Group Health Cooperative Medicare Advantage plan. A more detailed plan summary is provided to GHMA Plan Members directly.

In no event shall the benefits of the GHMA plan duplicate the benefits under the Group Medical Coverage Agreement. The benefits available to persons enrolled in both the Group Health Cooperative Medical Coverage Agreement and the Group Health Cooperative Medicare Advantage Plan will be the higher level of benefit available under the plans, as determined by Group Health Cooperative.

Unless otherwise stated, the provisions, limitations and exclusions, including provider access requirements of the Group Medical Coverage Agreement apply to the benefits available under the Group Health Cooperative Medicare Advantage Plan.

The benefits described in this outline apply only to Members who are covered under Medicare Part A and Part B, and who are enrolled in the Group Health Cooperative Medicare Advantage Plan as set forth in the Group Medical Coverage Agreement. This includes those Members with Medicare Part B only, who have been continuously enrolled in the Group Health Cooperative Medicare Advantage Plan (formerly known as Medicare+Choice), since December 31, 1998.

Benefit Category	Original Medicare (Benefits of the Federal Medicare Program)	GHC Medicare Employer Group Plan
SUMMARY OF BENEFITS		
INPATIENT CARE		
1 - Inpatient Hospital Care (includes substance abuse and rehabilitation services)	Member pays for each benefit period: <ul style="list-style-type: none"> – Days 1 - 60: an initial Deductible of \$952. – Days 61 - 90: \$238 each day. – Days 91 - 150: \$476 each lifetime reserve day. Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.	Member pays the lesser of the Group Cost Share or the following Copayment: <ul style="list-style-type: none"> – \$100 each day for day(s) 1-3 – \$0 each day for day(s) 4-90 for a Medicare-covered stay at a network hospital There is no Cost Share for additional days received at a network hospital. Member is covered for unlimited days each benefit period.
2 - Inpatient Mental Health Care	Member pays the same Deductible and Copayments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190 days in a psychiatric hospital in a lifetime.	Member pays the lesser of the Group Cost Share or the following Copayment: <ul style="list-style-type: none"> – \$100 each day for day(s) 1-3 – \$0 each day for day(s) 4-90 for a Medicare-covered stay at a network hospital Medicare beneficiaries may only receive 190 days in a psychiatric hospital in a lifetime.
3 - Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	Member pays for each benefit period, following at least a 3-day covered hospital stay: <ul style="list-style-type: none"> – Days 1 - 20: \$0 for each day. – Days 21 - 100: \$119.00 for each day. There is a limit of 100 days for each benefit period.	There is no Cost Share for services received at a skilled nursing facility. Member is covered at the Group benefit or up to 100 days per benefit period after a 3-day Medicare-certified hospital stay. Note: When a 3-day Medicare-covered hospital stay does not occur and the plan determines that the Member otherwise meets all Medicare criteria, the plan may

Benefit Category	Original Medicare (Benefits of the Federal Medicare Program)	GHC Medicare Employer Group Plan
		authorize Medicare-covered skilled nursing care for up to 100 days.
4 - Home Health Care (includes Medically Necessary intermittent skilled nursing care, home health aide services and rehabilitation services, etc.)	There is no Cost Share for all covered home health visits.	There is no Cost Share for Medicare-covered home health visits.
5 - Hospice	Member pays part of the cost for outpatient drugs and inpatient respite care. Member must receive care from a Medicare-certified hospice.	Member must receive care from a Medicare-certified hospice. Hospice services in a Medicare-certified hospice are reimbursed directly by Medicare when the Member enrolls in a Medicare-certified hospice.
OUTPATIENT CARE		
6 - Doctor Office Visits	Member pays 20% of Medicare-approved amounts after Medicare Part B Deductible is satisfied.	Member pays: <ul style="list-style-type: none"> – The lesser of the Group Cost Share or \$15 for each primary care doctor office visit for Medicare-covered services. – The lesser of the Group Cost Share or \$100 for each Medicare-covered ambulatory surgical center. – The lesser of the Group Cost Share or \$100 for each Medicare-covered outpatient hospital services visit. – Member pays the lesser of the Group Cost Share or \$15 for each Medicare-covered consultation and certain specialist visits.
7 - Chiropractic Services	Member is covered for manual manipulation of the spine to	Member pays the lesser of the Group Cost Share or \$15 for each

Benefit Category	Original Medicare (Benefits of the Federal Medicare Program)	GHC Medicare Employer Group Plan
	<p>correct subluxation, provided by chiropractors or other qualified providers.</p> <p>Routine care not covered.</p> <p>Member pays 20% of Medicare-approved amounts after Medicare Part B Deductible is satisfied.</p>	<p>Medicare-covered visit (manual manipulation of the spine to correct subluxation).</p> <p>Routine chiropractic services not covered.</p>
8 - Podiatry Services	<p>Member pays 20% of Medicare-approved amounts after Medicare Part B Deductible is satisfied.</p> <p>Member is covered for Medically Necessary foot care, including care for Medical Conditions affecting the lower limbs.</p> <p>Routine care not covered.</p>	<p>Member pays the lesser of the Group Cost Share or \$15 for each Medicare-covered visit (Medically Necessary foot care).</p> <p>Routine podiatry care not covered.</p>
9 - Outpatient Mental Health Care	<p>Member pays 50% of Medicare-approved amounts with the exception of certain situations and services for which Member pays 20% of approved charges after Medicare Part B Deductible is satisfied.</p>	<p>For Medicare-covered mental health services, Member pays the lesser of the Group Cost Share or \$15 for each individual/group therapy visit.</p>
10 - Outpatient Substance Abuse Care	<p>Member pays 20% of Medicare-approved amounts after Medicare Part B Deductible is satisfied.</p>	<p>There is no Cost Share for each Medicare-covered visit.</p>
11 - Outpatient Services/Surgery	<p>Member pays 20% of Medicare-approved amounts for the doctor after Medicare Part B Deductible is satisfied.</p> <p>Member pays 20% of outpatient facility charges after Medicare Part B Deductible is satisfied.</p>	<p>Member pays the lesser of the Group Cost Share or \$100 for each Medicare-covered visit to an ambulatory surgical center.</p> <p>Member pays the lesser of the Group Cost Share or \$100 for each Medicare-covered visit to an outpatient hospital facility.</p>
12 - Ambulance	<p>Member pays 20% of Medicare-</p>	<p>Member pays the lesser of the</p>

Benefit Category	Original Medicare (Benefits of the Federal Medicare Program)	GHC Medicare Employer Group Plan
Services (Medically Necessary ambulance services)	approved amounts or applicable Fee Schedule charge after Medicare Part B Deductible is satisfied.	Group Cost Share or \$75 per each one-way trip. Hospital to hospital ambulance transfers initiated by GHC are covered in full.
13 - Emergency Care (Member may go to any Emergency room if Member reasonably believes Emergency care is necessary.)	Member pays 20% of the facility charge or applicable Copayment for each Emergency room visit after Medicare Part B Deductible is satisfied; Member does NOT pay this amount if Member is admitted to the hospital for the same condition within 3 days of the Emergency room visit. Member pays 20% of doctor charges after Medicare Part B Deductible is satisfied. NOT covered outside the U.S. except under limited circumstances.	Member pays the lesser of the Group Cost Share or \$50 for each Medicare-covered Emergency room visit; Member does not pay this amount if Member is admitted to the hospital within 1 day for the same condition. Worldwide coverage.
14 - Urgently Needed Care (This is NOT Emergency care.)	Member pays 20% of Medicare-approved amounts or applicable Copayment after Medicare Part B Deductible is satisfied. NOT covered outside the U.S. except under limited circumstances.	Member pays the lesser of the Group Cost Share or \$15 for each Medicare-covered urgently needed care visit. Worldwide coverage.
15 - Outpatient Rehabilitation Services (occupational therapy, physical therapy, speech and language therapy)	Member pays 20% of Medicare-approved amounts after Medicare Part B Deductible is satisfied.	Member pays the lesser of the Group Cost Share or \$15 for each occupational therapy, physical therapy and/or speech/language therapy visit. Medicare will cover up to \$1,750 a year for physical and speech therapy services combined; Medicare will cover up to \$1,750 a year for occupational therapy services. These limits apply to outpatient therapy services provided in outpatient medical centers and skilled nursing facilities. Additional visits available if Medically Necessary as determined by GHC.

Benefit Category	Original Medicare (Benefits of the Federal Medicare Program)	GHC Medicare Employer Group Plan
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
16 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	Member pays 20% of Medicare-approved amounts after Medicare Part B Deductible is satisfied.	Member pays the lesser of the Group Cost Share or 20% of the cost for each Medicare-covered item.
17 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	Member pays 20% of Medicare-approved amounts after Medicare Part B Deductible is satisfied.	Member pays the lesser of the Group Cost Share or 20% of the cost for each Medicare-covered item.
18 - Diabetes Self-Monitoring Training and Supplies (includes coverage for glucose monitors, test strips, lancets and self-management training)	Member pays 20% of Medicare-approved amounts after Medicare Part B Deductible is satisfied.	<p>There is no Copayment for diabetes self-monitoring training.</p> <p>Member pays the lesser of the Group Cost Share or 20% of the cost for each Medicare-covered diabetes supply item.</p> <p>Member pays the lesser of the Group Cost Share or \$15 for each separate office visit.</p>
19 - Diagnostic Tests, X-Rays and Lab Services	<p>Member pays 20% of Medicare-approved amounts, except for approved lab services after Medicare Part B Deductible is satisfied.</p> <p>There is no Cost Share for Medicare-approved lab services.</p>	<p>There is no Cost Share for the following Medicare-covered service(s):</p> <ul style="list-style-type: none"> – clinical/diagnostic lab services – radiation therapy – X-ray visits
20 - Bone Mass Measurement (for people with Medicare who are at risk)	Member pays 20% of Medicare-approved amounts after Medicare Part B Deductible is satisfied.	<p>There is no Cost Share for each Medicare-covered bone mass measurement.</p> <p>Member pays the lesser of the Group Cost Share or \$15 for each separate office visit.</p>
21 - Colorectal Screening Exams (for people with Medicare age 50 and older)	Member pays 20% of Medicare-approved amounts after Medicare Part B Deductible is satisfied.	<p>There is no Cost Share for Medicare-covered colorectal screening exams.</p> <p>Member pays the lesser of the Group Cost Share or \$15 for each separate office visit.</p>

Benefit Category	Original Medicare (Benefits of the Federal Medicare Program)	GHC Medicare Employer Group Plan
		Member pays the lesser of the Group Cost Share or \$100 for each Medicare-covered ambulatory surgical center visit and for each Medicare-covered outpatient hospital services visit.
22 - Immunizations (Flu vaccine, Hepatitis B vaccine -for people with Medicare who are at risk, pneumonia vaccine)	<p>There is no Cost Share for the pneumonia and flu vaccines.</p> <p>Member pays 20% of Medicare-approved amounts for the Hepatitis B vaccine after Medicare Part B Deductible is satisfied.</p> <p>Member may only need the pneumonia vaccine once in the Member's lifetime. Contact doctor for further details.</p>	<p>There is no Cost Share for the pneumonia and flu vaccines.</p> <p>No Referral necessary for Medicare-covered flu and pneumonia vaccines.</p> <p>There is no Cost Share for the Hepatitis B vaccine.</p>
23 - Mammograms (annual screening) (for women with Medicare age 40 and older)	<p>Member pays 20% of Medicare-approved amounts.</p> <p>No Referral necessary for Medicare-covered screenings.</p>	<p>There is no Cost Share for Medicare-covered screening mammograms.</p> <p>Member pays the lesser of the Group Cost Share or \$15 for each separate office visit.</p>
PREVENTIVE SERVICES		
24 - Pap Smears and Pelvic Exams (for women with Medicare)	<p>There is no Cost Share for a pap smear once every 2 years, annually for beneficiaries at high risk.</p> <p>Member pays 20% of Medicare-approved amounts for pelvic exams.</p>	There is no Cost Share for Medicare-covered pap smears and pelvic exams.
25 - Prostate Cancer Screening Exams (for men with Medicare age 50 and older.)	There is no Cost Share for approved lab services and a Cost Share of 20% of Medicare-approved amounts for other related services after Medicare Part B Deductible is satisfied.	There is no Cost Share for Medicare-covered prostate cancer screening exams.

Benefit Category	Original Medicare (Benefits of the Federal Medicare Program)	GHC Medicare Employer Group Plan
26 - Outpatient Prescription Drugs	Most prescription drugs not covered unless Member purchases Medicare Part D.	Most drugs not covered by Medicare. See Group outpatient prescription drug benefit.
ADDITIONAL BENEFITS (WHAT ORIGINAL MEDICARE DOES NOT COVER)		
27 - Dental Services	Not covered unless Medicare criteria met.	Not covered unless Medicare criteria met.
28 - Hearing Services	<p>Routine hearing exams and hearing aids not covered.</p> <p>Member pays 20% of Medicare-approved amounts for diagnostic hearing exams after Medicare Part B Deductible is satisfied.</p>	<p>There is no Cost Share for hearing aids up to 1 aid(s).</p> <p>Member pays:</p> <ul style="list-style-type: none"> – The lesser of the Group Cost Share or \$15 for each Medicare-covered hearing exam (diagnostic hearing exams). – \$0 for each routine hearing test up to 1 test(s) once every 24-months. – \$0 for each fitting-evaluation for a hearing aid up to 1 fitting(s)-evaluation(s) once every 24-months. <p>Benefit limited to \$250 for hearing aids once every 24-months. Must use plan providers.</p>
29 – Vision Services	<p>Member is covered for one pair of eyeglasses or contact lenses after each cataract surgery after Medicare Part B Deductible is satisfied.</p> <p>Members with Medicare who are at risk are covered for annual glaucoma screenings after Medicare Part B Deductible is satisfied.</p> <p>Member pays 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye after Medicare Part B Deductible is</p>	<p>There is no Cost Share for the following items:</p> <ul style="list-style-type: none"> – Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery). – Glasses, limited to 1 pair(s) of standard glasses covered up to UCR once every 24-months, or; – Contacts, limited to 1 pair(s) of standard contacts covered up to UCR once every 24-months. <p>Member pays:</p> <ul style="list-style-type: none"> – The lesser of the Group Cost

Benefit Category	Original Medicare (Benefits of the Federal Medicare Program)	GHC Medicare Employer Group Plan
	<p>satisfied.</p> <p>Routine eye exams and glasses not covered.</p>	<p>Share or \$15 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye).</p> <ul style="list-style-type: none"> – The lesser of the Group Cost Share or \$15 for each GHC-covered routine eye exam, limited to 1 exam(s) once every 24-months. <p>Benefit limited to \$100 toward purchase of frames once every 24 months.</p> <p>Must use plan providers.</p>
30 - Physical Exams	<p>If coverage to Medicare Part B begins on or after January 1, 2005, Member may receive a one time physical exam within the first six months of the Member's new Part B coverage. This will not include laboratory tests. Contact plan for further details. Member pays 20% of the Medicare-approved amount after Medicare Part B Deductible is satisfied.</p>	<p>A one time only physical exam is available within the first six months of the Member's new Part B coverage. The exam does not include laboratory tests.</p> <p>Member pays the lesser of the Group Cost Share or \$15 for the office visit.</p> <p>There is no Cost Share for routine physical exams. Limited to 1 exam(s) every two years.</p>
Health/Wellness Education	<p>Medicare will pay for two cessation-counseling attempts per year; each attempt includes 4 sessions each of either shorter visits of 3 to 10 minutes each, or longer visits (longer than 10 minutes each) depending on what the Member and their doctor decide.</p>	<p>Covered in full for the following:</p> <p><u>SilverSneakers</u> The SilverSneakers fitness program is available on a voluntary basis.</p> <p><u>Lifetime Fitness</u> The Lifetime Fitness program is available on a voluntary basis.</p> <p>For more information, call the GHC Resource Line toll-free at 1-800-992-2279 or 206-326-2800, or the TTY line at 711 or 1-800-833-6388.</p>

Benefit Category	Original Medicare (Benefits of the Federal Medicare Program)	GHC Medicare Employer Group Plan
		<p>Must use plan providers.</p> <p>In addition to the original Medicare smoking & tobacco use cessation benefit, Member receives the following GHC covered benefit:</p> <p><u>Smoking & Tobacco Use Cessation:</u></p> <p>When Member is enrolled and actively participating in the Free and Clear Program™, services provided through GHC related to smoking and tobacco use cessation are covered, limited to: Participation in one individual or group program per calendar year; One course of nicotine replacement therapy per calendar year; Educational materials covered in full.</p> <p>Must use plan providers.</p>
Transportation (Routine)	Not covered.	Routine transportation not covered. Medically Necessary ambulance services are covered (see section 12).
Point of Service		<p>Non-emergent and/or non-urgently needed care received while temporarily traveling outside GHC's Medicare Service Area is payable at Medicare benefit levels up to \$2,000 per Member per calendar year. The GHC MA Plan pays 80% of Medicare allowable reimbursement schedules for Medicare covered services ONLY. Member is responsible for all Medicare inpatient and outpatient Deductibles and Coinsurances.</p> <p>Member pays the lesser of the Group Cost Share or 20% of the cost for each stay in a non-network</p>

Benefit Category	Original Medicare (Benefits of the Federal Medicare Program)	GHC Medicare Employer Group Plan
		hospital or inpatient psychiatric hospital.



2006 Medicare Endorsement Group Health Cooperative Medicare Advantage Plan

This Endorsement does not constitute a “Medicare Supplemental” contract.

The provisions of the Group Medical Coverage Agreement shall remain in effect except as modified by the addition of the provisions, exclusions, and limitations contained in this Medicare Endorsement.

In no event shall the benefits under this Endorsement duplicate the benefits under the Group Medical Coverage Agreement. The benefits available to persons enrolled in both the Group Health Cooperative Medical Coverage Agreement and the Group Health Cooperative Medicare Advantage Plan will be the higher level of benefit available under the plans as determined by Group Health.

The benefits and exclusions described in this Endorsement apply only to members who are covered under Medicare Part A and Part B, and who are enrolled in the Group Health Cooperative Medicare Advantage Plan as set forth in Section III.D., of the Group Medical Coverage Agreement. This includes those members with Medicare Part B only, who have been continuously enrolled in the Group Health Cooperative Medicare Advantage Plan (formerly known as Medicare+Choice), since December 31, 1998.

Except as defined by federal regulations, all members entitled to, or eligible to purchase Medicare and who live in the Group Health Cooperative Medicare Advantage Plan service area, must enroll in the Group Health Cooperative Medicare Advantage Plan upon such entitlement or eligibility.

Incorporated into this endorsement is the GHC Medicare Advantage Plan Explanation of Coverage (EOC). The EOC sets forth the benefits, provisions and requirements of the GHC MA plan. The EOC document has been approved by The Centers for Medicare and Medicaid (CMS) Services

Welcome to the Group Health Cooperative (GHC) Medicare Advantage (MA) Plan!

We are pleased that you've chosen the GHC MA Plan.

The GHC MA Plan is a Health Maintenance Organization “HMO” for people with Medicare.

Now that you are enrolled in the GHC MA Plan you are getting your care through Group Health Cooperative.

The GHC MA Plan, an HMO, is offered by Group Health Cooperative. The GHC MA Plan is not a “Medigap” or supplemental Medicare insurance policy.

This booklet explains how to get your Medicare services through the GHC MA Plan.

This booklet, together with your enrollment form, and any amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of the GHC MA Plan. It also explains our responsibilities to you. The information in this booklet is in effect for the time period from January 1, 2006, through December 31, 2006.

- You are still covered by Original Medicare, but you are getting your Medicare services as a member of the GHC MA Plan. This booklet gives you the details, including:
- What is covered in the GHC MA Plan and what is not covered.
- How to get the care you need, including some rules you must follow.
- What you will have to pay for your health plan.
- What to do if you are unhappy about something related to getting your covered services.
- How to leave the GHC MA Plan, and other Medicare options that are available.

If you need to receive this booklet in a different format, please call us so we can send you a copy. Section 1 of this booklet tells how to contact us.

Please tell us how we're doing

We want to hear from you about how well we are doing as your health plan. You can call or write to us at any time (Section 1 of this booklet tells how to contact us). Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our members to tell about their experiences with the GHC MA Plan. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

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SECTION 1. Telephone numbers and other information for reference

How to contact GHC Customer Service

If you have any questions or concerns, please call or write to GHC Customer Service. We will be happy to help you. Our business hours are Monday-Friday, 8:00 to 5:00 p.m.

CALL 1-888-901-4636. This number is also on the cover of this booklet for easy reference. Calls to this number are free.

TTY 711 or 1-800-833-6388. This number requires special telephone equipment. It is on the cover of this booklet for easy reference. Calls to this number are free.

FAX 206-901-4612.

WRITE GHC Customer Service Department, P.O. Box 34589, Seattle, WA 98124-1589.

EMAIL info@ghc.org

How to contact the Medicare program and 1-800-MEDICARE (TTY 1-877-486-2048) helpline

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

CMS is the federal agency in charge of the Medicare program. CMS stands for Centers for Medicare & Medicaid Services. CMS contracts with and regulates Medicare Health Plans including GHC and Medicare Private Fee-for-Service organizations.

Here are ways to get help and information about Medicare from CMS:

- Call **1-800-MEDICARE** (1-800-633-4227) to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. The TTY number is 1-877-486-2048 (you need special telephone equipment to use this number). Calls to these numbers are free.
- Use a computer to look at www.medicare.gov, the official **government website for Medicare information**. This website gives you a lot of up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has a tool to help you compare Medicare Advantage Plans and Prescription Drug Plans in your area. You can also search the “Helpful Contacts” section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this website using their computer.

SHIBA – an organization in Washington State that provides free Medicare help and information

“SHIBA” stands for Statewide Health Insurance Benefits Advisors. SHIBA is a state organization paid by the Federal Government to give free health insurance information and help to people with Medicare. SHIBA can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. SHIBA has information about Medicare Advantage Plans and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in the Medicare Advantage plan, and information about special Medigap rights for people who have tried a Medicare Advantage plan (like the GHC MA Plan) for the first time. (Medicare Advantage is the new name for Medicare+Choice). Section 11 has more information about your Medigap guaranteed issue rights.

You can contact SHIBA: Write to SHIBA at 4224 6th Ave., Bldg-4, Olympia, WA 98504-0256. SHIBA can be reached by calling, 1-800-397-4422, or 1-800-562-6900, or TTY 1-360-664-3154 for the “hearing impaired”. You can also find the website for SHIBA at www.medicare.gov on the web.

Qualis Health/Quality Improvement Organization – a group of doctors and health professionals in Washington state who review medical care and handle certain types of complaints from patients with Medicare

“QIO” stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the Federal Government to check on and help improve the care given to Medicare patients.

There is a QIO in each state. QIOs have different names, depending on which state they are in. In Washington State, the QIO is called Qualis Health. The doctors and other health experts in Qualis Health review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency or comprehensive outpatient rehabilitation stay is ending too soon. See Section 9 for more information about complaints.

You can contact Qualis Health the QIO in Washington state, at PO BOX 33400, Seattle, WA 98133-0400 or 10700 Meridian Ave. N., Suite 100, Seattle, WA 98133-9075; telephone number (206) 364-9700 or Fax: (206) 368-2419.

Other organizations (including Medicaid, Social Security Administration)

Medicaid agency – a state government agency that handles health care programs for people with low incomes

Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact the Washington State Department of Social and Health Services (DSHS) Medical Assistance Administration (MAA) at 1-800-562-3022, or write to the MAA Customer Service Center, P.O. Box 45505, Olympia, WA 98504-5505. **The TTY/TDD number (for people who have difficulties with hearing or speech) is 1-800-848-5429.**

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits; disability; family benefits; survivors' benefits; and benefits for the aged, blind, and disabled. You can call the Social Security Administration at 1-800-772-1213. The TTY number is 1-800-325-0778 (you need special telephone equipment to use this number). Calls to these numbers are free. You can also visit www.ssa.gov on the web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). The TTY number is 312-751-4701 (you need special telephone equipment to use this number). You can also visit www.rrb.gov on the web.

Employer (or "Group") Coverage

If you get your benefits from your current or former employer, or your spouse's current or former employer, call the employer's benefits administrator if you have any questions about your benefits, plan premiums, or the open enrollment season.

SECTION 2 Getting the care you need, including some rules you must follow

Enrollment in the GHC MA Plan

An MA eligible individual may not be enrolled in more than one MA plan at any given time. Members may be enrolled in only one Group Health Cooperative Individual MA health plan or one of Group Health Cooperative's subsidiary's employer group medical coverage plan at any given time.

What is the GHC MA Plan?

Now that you are enrolled in the GHC MA Plan, you are getting your Medicare through GHC. The GHC MA Plan is offered by GHC, and is a HMO for people with Medicare. The Medicare program pays us to manage health services for people with Medicare who are members of the GHC MA Plan. (The GHC MA Plan is **not** a Medicare supplement policy. See Section 13 for a definition of Medicare supplement policy. Medicare supplement policies are sometimes called "Medigap" insurance policies.) GHC provides medical services through Medicare-certified health care facilities. In addition, our health care professionals are in compliance with Medicare credentialing standards.

This booklet explains your benefits and services, what you have to pay, and the rules you must follow to get your care. The GHC MA Plan gives you all of the usual Medicare services that are covered for everyone with Medicare.

Since the GHC MA Plan is a Medicare HMO, this means that you will be getting most or all of your health services from the doctors, hospitals, and other health providers that are part of the GHC MA Plan.

Since these doctors, hospitals, and other providers are the ones we are paying to provide your care, they are the ones you must use (except in special situations such as emergencies).

Use your plan membership card instead of your red, white, and blue Medicare card

Now that you are a member of the GHC MA Plan, you have a GHC MA Plan membership card. Here is a sample card to show what it looks like:



During the time you are a plan member and using plan services, **you must use your plan membership card instead of your red, white, and blue Medicare card to get covered services.** (See Section 4 for a definition and list of covered services.) Keep your red, white, and blue Medicare card in a safe place in case you are asked to show it, but for the most part you will not use it to get services while you are a member. If you get covered services using your red, white, and blue Medicare card instead of your GHC MA Plan membership card while you are a plan member, the Medicare program will not pay for these services and you may have to pay the full cost yourself.

Please carry your GHC MA Plan membership card with you at all times. You will need to show this card when you receive covered services such as at the doctor's office or emergency room. If your membership card is ever damaged, lost, or stolen, call GHC Customer Service right away and we will send you a new card.

Help us keep your membership record up to date

Group Health has a file of information about you as a plan member. Doctors, hospitals, and other plan providers use this membership record to know what services are covered for you. The membership record has information from your enrollment form, including your address and telephone number. It shows your specific GHC MA Plan coverage, and other information. Section 8 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up to date by letting GHC Customer Service know right away if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, tell GHC Customer Service about any changes in health insurance coverage you have from other sources, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims against another driver in an automobile accident. Call the number on the cover of this booklet to contact GHC Customer Service.

What is the geographic service area for the GHC MA Plan?

The counties and parts of counties in our service area are King, Mason, Pierce, Spokane and Thurston, Counties. GHC Service Area in Mason County includes only these ZIP Codes: 98524, 98528, 98546, 98548, 98555, 98584, 98588 and 98592.

Using plan providers to get services covered by the GHC MA Plan

You will be using plan providers to get your covered services

Now that you are a member of the GHC MA Plan, with few exceptions, **you must use plan providers to get your covered services.**

- **What are “plan providers”?** “Providers” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “plan providers” when they participate in the GHC MA Plan. When we say that plan providers “participate in the GHC MA Plan,” this means that we have arranged with them to coordinate or provide covered services to members of the GHC MA Plan.
- **What are “covered services”?** “Covered services” is the general term we use in this booklet to mean all of the health care services and supplies that are covered by the GHC MA Plan. Covered services are listed in the Benefits Chart in Section 4.

As we explain below, you will have to choose one of our plan providers to be your PCP, which stands for Personal Care Physician. Your PCP will provide or arrange for most or all of your covered services. Care or services you get from non-plan providers will not be covered, with few exceptions such as emergencies. (When we say “non-plan providers,” we mean providers that are **not** part of the GHC MA Plan.)

The Medicare Provider Directory gives you a list of plan providers

Every year as long as you are a member of the GHC MA Plan we will send you a GHC Medicare Advantage Provider Directory, which gives you a list of plan providers. If you don’t have the GHC Medicare Provider Directory, you can get a copy from GHC Customer Service (call the number on the cover of this booklet to contact GHC Customer Service). You can ask GHC Customer Service for more information about plan providers, including their qualifications and experience.

GHC Customer Service can give you the most up-to-date information about changes in plan providers and about which ones are accepting new patients.

Access to care and information from plan providers

You have the right to get timely access to plan providers and to all services covered by the plan. (“Timely access” means that you can get appointments and services within a reasonable period of time.) You have the right to get full information from your doctors when you go for medical care. You have the right to participate fully in decisions about your health care, which includes the right to refuse care. Please see Section 8 for more information about these and other rights you have, and what you can do if you think your rights have not been respected.

Choosing Your PCP (PCP means Personal Care Physician)

What is a “PCP”?

When you become a member of the GHC MA Plan, you must choose a plan provider to be your PCP. Your PCP is a health care professional who meets state requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a plan member. For example, in order to see a specialist, you usually need to get your PCP’s approval first (this is called getting a “referral” to a specialist).

How do you choose a PCP?

To get started using Group Health, the most important thing for you to do first is to choose a Personal Care Physician. Some members choose a PCP close to home; others pick a PCP close to work. There are no special rules to follow. Your PCP should be in a convenient location for you. If there is a particular GHC specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital. You should also ask whether the PCP has a referral relationship with any specialist or hospital you are currently seeing. A list of providers and their telephone numbers are listed in your Group Health Medicare Provider Directory or you may contact GHC Customer Service for details.

You may change your PCP at any time (as explained later in this section). Simply call GHC Customer Service and we will check to make sure the doctor you choose is accepting new patients. Please let us know if you are getting home health agency services or using durable medical equipment so we can help with the transfer of your care or equipment. We will make the change for you and tell you over the phone when this change will go into effect.

Getting care from your PCP

You will usually see your PCP first for most of your routine health care needs. As we explain below and in Section 4, there are some types of covered services you can get on your own, without contacting your PCP first.

Besides providing much of your care, your PCP will help arrange or coordinate the rest of the covered services you get as a plan member. This includes your x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care. “Coordinating” your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, your PCP must give approval in advance (such as giving you a referral to see a specialist). In some cases, your PCP will “also” need to get prior authorization (prior approval). Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your new PCP’s office. Section 8 tells how we will protect the privacy of your medical records and personal health information.

What if you need medical care when your PCP’s office is closed?

What to do if you have a medical emergency or urgent need for care

In an emergency, you should get care immediately. You do **not** have to contact your PCP or get permission in an emergency. You can dial 911 for immediate help by phone, or go directly to the nearest emergency room, hospital, or urgent care center. Section 3 tells what to do if you have a medical emergency or urgent need for care.

What to do if it is not a medical emergency

If you need to talk with your PCP or get medical care when the PCP's office is closed, and it is *not* a medical emergency, call GHC Consulting Nurse 24-hour toll-free number located on the back of your GHC MA Plan membership card (1-800-297-6877) or the toll-free TTY at 711 or 1-800-833-6388 (this number requires special telephone equipment and is used by people who have difficulties with hearing or speaking). There will always be a provider on call to help you.

See Section 3 for more information about what to do if you have an urgent need for care. If you have an urgent need for care while you are in the service area, we expect you to get this care from plan providers. In most cases, we will not pay for urgently needed care that you get from a *non-plan provider* while you are in the plan's service area. (Our service area is listed earlier in this Section.)

Getting care from specialists

Group Health Cooperative offers members an option of self-referring to some Group Health specialists at Group Health-operated medical centers only. A specialist is a doctor who provides health care services for a specific disease or part of the body. The specialties to which a member may self refer to Group Health specialists at Group Health-operated medical centers are: Allergy, Audiology, Behavioral Health (Chemical Dependency & Mental Health), Cardiology, Dermatology, Gastroenterology, General Surgery, Hematology, Hospice, Internal Medicine, Nephrology, Neurology, OB/Gyn, Oncology, Ophthalmology, Optometry, Orthopedics, Otolaryngology (ENT), Smoking Cessation, and Urology. These are the only specialties to which you may use the self-referral option and you may see these Group Health specialists at Group Health-operated medical centers only.

When your PCP thinks that you need specialized treatment not including types of covered services you can get on your own, he or she will give you a referral (approval in advance) to see a plan specialist. A specialist is a doctor who provides health care services for a specific disease or part of the body. Examples include physical therapists (who provide evaluation of patients' conditions and develop treatment programs designed to restore patients to a normal or optimum state of health and functioning), speech therapy providers (who provide care for patients experiencing speech, language, learning, swallowing, feeding problems), and anesthesiologists (who provide management of anesthesia for surgical patients).

It is very important to get a referral from your PCP before you see a plan specialist (there are a some exceptions, including GHC's self-referral specialists' mentioned above, and routine women's health care, that we explain later in this section). **If you don't have a referral before you receive services from a specialist not on the self referral list above, you may have to pay for these services yourself.** If the specialist wants you to come back for more care, check first to be sure that the referral you got from your PCP covers more visits to the specialist.

If there are specific specialists you want to use, find out whether your PCP sends patients to these specialists. Each plan PCP has certain plan specialists they use for referrals. This means that **the GHC MA Plan specialists you can use may depend on which person you chose to be your PCP.** You can change your PCP at any time if you want to see a plan specialist that your current PCP cannot refer you to. Later in this section, under "Choosing your PCP," we tell you how to change your PCP. If there are specific hospitals you want to use, find out whether your PCP uses these hospitals.

There are some services you can get on your own, without a referral

As explained above, you will get most of your routine or basic care from your PCP, and your PCP will coordinate the rest of the covered services you get as a plan member. If you get services from any doctor, hospital, or other health care provider without getting a referral in advance from your PCP, you may have to pay for these services yourself – even if you get the services from a plan provider. *But there are a few exceptions:* you can get the following services on your own, without a referral or approval in advance from your PCP. This is called “**self-referral**” when you get these services on your own. You still have to pay your copayment for these services.

- Routine women’s health care, which includes breast exams, mammograms (x-rays of the breast), pap tests, and pelvic exams. This care is covered without a referral from your PCP *only* if you get it from a plan provider.
- Flu shots and pneumonia vaccinations (as long as you get them from a plan provider).
- Chiropractic services (as long as you get them from a plan provider).
- Emergency services, whether you get these services from plan providers or non-plan providers (see Section 3 for more information).
- Urgently needed care that you get from non-plan providers when you are temporarily outside the plan’s service area. Also, urgently needed care that you get from non-plan providers when you are in the service area but, because of unusual or extraordinary circumstances, the plan providers are temporarily unavailable or inaccessible. (See Section 3 for more information about urgently needed care. Earlier in this section, we explain the plan’s service area.)
- Renal dialysis (kidney) services that you get when you are temporarily outside the plan’s service area. If possible, please let us know before you leave the service area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the service area.
- Group Health Cooperative offers members an option of self-referring to some Group Health specialists at Group Health-operated medical centers only. A specialist is a doctor who provides health care services for a specific disease or part of the body. The specialties to which a member may self refer to Group Health specialists at Group Health-operated medical centers are: Allergy, Audiology, Behavioral Health (Chemical Dependency & Mental Health), Cardiology, Dermatology, Gastroenterology, General Surgery, Hematology, Hospice, Internal Medicine, Nephrology, Neurology, OB/Gyn, Oncology, Ophthalmology, Optometry, Orthopedics, Otolaryngology (ENT), Smoking Cessation, and Urology. These are the only specialties to which you may use the self-referral option and you may see these Group Health specialists at Group Health-operated medical centers only.

Getting care when you travel or are away from the plan’s service area

If you need care when you are outside the service area, your coverage is limited. The only services we cover when you are outside our service area are care for a medical emergency, urgently needed care, renal dialysis, and care that GHC or a plan provider has approved in advance. See Section 3 for more information about care for a medical emergency and urgently needed care. If you have questions about what medical care is covered when you travel, please call GHC Customer Service at the telephone number on the cover of this booklet.

Your GHC MA Plan offers a Point-of-Service (POS) non-emergency and/or non-urgently needed care benefit, while you are temporarily traveling outside the service area. This benefit is payable at Medicare benefit levels up to \$2,000 per member per calendar year. The plan pays 80% of Medicare allowable

reimbursement schedules for Medicare covered services only. You are responsible for all Medicare inpatient, and outpatient deductibles and coinsurances. Be sure to check with GHC Customer Service at the telephone number on the cover of this booklet if you have questions about what medical care is covered when you travel. If you plan to permanently move or be away from the service area for more than six months, we will have to disenroll you. For more information, see Section 11.

How to change your PCP

You may change your PCP for any reason, at any time. To change your PCP, call GHC Customer Service at the number on the cover of this booklet. When you call, be sure to tell GHC Customer Service if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment).

GHC Customer Service will help make sure that you can continue with the specialty care and other services you have been getting when you change to a new PCP. They will also check to be sure that the PCP you want to switch to is accepting new patients. GHC Customer Service will change your membership record to show the name of your new PCP, and tell you when the change to your new PCP will take effect.

What if your doctor leaves the GHC MA Plan?

Sometimes a PCP, specialist, clinic, or other plan provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of the GHC MA Plan. If your PCP leaves the GHC MA Plan, we will let you know, and help you switch to another PCP so that you can keep getting covered services.

SECTION 3 Getting care if you have a medical emergency or an urgent need for care

What is a “medical emergency”?

A “medical emergency” is when you **reasonably believe that your health is in serious danger**—when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

What should you do if you have a medical emergency?

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room. **You do not need to get permission first from your PCP (Personal Care Physician) or other plan provider.** (Section 2 tells about your PCP and plan providers.)
- Make sure that your PCP knows about your emergency, because your PCP will need to be involved in following up on your emergency care.

You or someone else should call to tell your PCP about your emergency care as soon as possible, preferably within 48 hours. (The number to call is located on the back of your membership card).

Your PCP will help manage and follow up on your emergency care

Your PCP will talk with the doctors who are giving you emergency care to help manage and follow up on your care. When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over, what happens next is called “post-stabilization care.” Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines. In general, your PCP will try to arrange for plan providers to take over your care as soon as your medical condition and the circumstances allow.

What is covered if you have a medical emergency?

- You can get covered emergency medical care whenever you need it, anywhere in the world.
- **Ambulance** services are covered in situations where other means of transportation would endanger your health.

What if it wasn’t really a medical emergency?

Sometimes it can be hard to know if you have a real medical emergency. For example, you might go in for emergency care—thinking that your health is in serious danger—and the doctor may say that it was not a medical emergency after all. If this happens to you, you are still covered for the care you got to determine what was wrong, (as long as you thought your health was in serious danger, as explained in “What is a ‘medical emergency’” above). However, please note that:

- If you get any additional care after the doctor says it was *not* a medical emergency, we will pay our portion of the covered additional care **if you get it from a plan provider**.
- If you get any additional care from a *non-plan provider* after the doctor says it was not a medical emergency, we will usually *not* cover the additional care. There is an exception: we will pay our portion of the covered additional care from a non-plan provider if you are out of our service area, as long as the additional care you get meets the definition of “urgently needed care” that is given below.

What is “urgently needed care”? (This is different from a medical emergency)

“Urgently needed care” is **when you need medical attention right away for an unforeseen illness or injury**, and it is not reasonable given the situation for you to get medical care from your PCP or other plan providers. In these cases, your health is *not* in serious danger. As we explain below, how you get “urgently needed care” depends on whether you need it when you are in the plan’s service area, or outside the plan’s service area. Section 2 tells about the plan’s service area.

What is the difference between a “ medical emergency” and “urgently needed care”?

The main difference between an urgent need for care and a medical emergency is in the danger to your health. “Urgently needed care” is if you need medical help immediately, but your health is not in serious danger. A “medical emergency” is if you believe that your health is in serious danger.

Getting urgently needed care when you are in the plan’s service area

If you have a sudden illness or injury that is not a medical emergency, and you are in the plan’s service area, please call your PCP or GHC Consulting Nurse 24-hour toll-free number located on the back of your GHC MA Plan membership card (1-800-297-6877) or toll-free TTY at 711 or 1-800-833-6388 (this number requires special telephone equipment and is used by people who have difficulties with hearing

or speaking) for instructions. There will always be a doctor on call to help you. Keep in mind that if you have an urgent need for care while you are in the plan's service area, we expect you to get this care from plan providers. In most cases, we will not pay for urgently needed care that you get from a *non-plan provider* while you are in the plan's service area.

Getting urgently needed care when you are outside the plan's service area

The GHC MA Plan covers urgently needed care that you get from non-plan providers when you are outside the plan's service area. If you need urgent care while you are outside the plan's service area, we prefer that you call your PCP first, whenever possible. If you are treated for an urgent care condition while out of the service area, we prefer that you return to the service area to get follow-up care through your PCP. However, we will cover follow-up care that you get from non-plan providers outside the plan's service area as long as the care you are getting still meets the definition of "urgently needed care." As explained in Section 2, we cover renal (kidney) dialysis services that you get when you are temporarily outside the plan's service area (for up to six months in a row).

SECTION 4 Benefits Chart – a list of the covered services you get as a member of the GHC MA Plan

What are covered services?

This section describes the medical benefits and coverage you get as a member of the GHC MA Plan. **"Covered services," means the medical care, services, supplies, and equipment that are covered by the GHC MA Plan.** This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. The section that follows (Section 5) tells about **services that are *not* covered** (these are called "exclusions.")

There are some conditions that apply in order to get covered services **Some general requirements apply to *all* covered services**

The covered services listed in the Benefits Chart in this section are covered only when *all* requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare program and GHC guidelines.
- The medical care, services, supplies, and equipment that are listed as "covered services" must be medically necessary. Certain preventive care and screening tests are also covered. (See Section 13 for a definition of "medically necessary.")
- With few exceptions, covered services must either be provided by plan providers, be approved in advance by plan providers, or be authorized by GHC. The exceptions are care for a medical emergency, urgently needed care, and renal (kidney) dialysis you get when you are outside the plan's service area.

In addition, some covered services require “prior authorization” in order to be covered

Some of the covered services listed in the Benefits Chart in this section are covered only if your doctor or other plan provider gets “prior authorization” (approval in advance) from GHC. Covered services that need prior authorization are marked by *italics text* in the Benefits Chart.

Benefits Chart – a list of covered services

Benefits chart – your covered services	What you must pay when you get these covered services
INPATIENT SERVICES	
<p>Inpatient hospital care For more information about hospital care, see Section 6.</p> <p>Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Rehabilitation services, such as physical therapy, occupational therapy, and speech therapy services. • <i>Under certain conditions, the following types of transplants are covered:</i> corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral. See Section 6 for more information about transplants. • Blood - coverage of storage and administration begins with the first pint of blood that you need. • Physician Services. 	<p>You pay:</p> <ul style="list-style-type: none"> - \$100 each day for day(s) 1-3 - \$0 each day for day(s) 4-90 <p>for a Medicare-covered stay at a network hospital</p> <p>There is no copayment for additional days received at a network hospital.</p> <p>You are covered for unlimited days each benefit period.</p> <p><i>Prior authorization required.</i></p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p>Inpatient mental health care</p> <p>Includes mental health care services that require a hospital stay</p>	<p>You pay:</p> <ul style="list-style-type: none"> - \$100 each day for day(s) 1-3 - \$0 each day for day(s) 4-90 <p>for a Medicare-covered stay at a network hospital.</p> <p>Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.</p> <p><i>Prior authorization required.</i></p>
<p>Skilled nursing facility care For more information about skilled nursing facility care, see Section 6.</p> <p>Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood - coverage of storage and administration begins with the first pint of blood that you need. • Medical and surgical supplies. • Laboratory tests. • X-rays and other radiology services. • Use of appliances such as wheelchairs. • Physician services. 	<p>There is no copayment for services in a Skilled Nursing Facility.</p> <p><i>No prior hospital stay is required.</i></p> <p>(See page 41 for additional information about Skilled Nursing Facility). **</p> <p>You are covered for 100 days each benefit period.</p> <p>Skilled Nursing Facility (Group Health Covered): When a 3 day Medicare covered hospital stay does not occur and the plan determines that the member otherwise meets all Medicare criteria for an acute inpatient hospital stay at the time of admission to a Medicare Certified Skilled Nursing Facility, the plan</p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p>Skilled nursing facility care (Cont.) For more information about skilled nursing facility care, see Section 6.</p>	<p>may authorize Medicare covered Skilled Nursing Facility Care up to the Medicare skilled Nursing Facility day limit per benefit period. All Medicare criteria must be met and the stay must be authorized in advance by the plan.</p> <p><i>Prior authorization required.</i></p> <p>Medicare will limit how much it covers for certain therapy services starting January 1, 2006. For total physical and speech therapy services, Medicare will cover up to \$1,750 a year; For occupational therapy services Medicare will cover up to \$1,750 a year. These limits apply to outpatient therapy services provided in outpatient medical centers and skilled nursing facilities.</p>
<p>Home health care For more information about home health care see Section 6.</p> <p>Home Health Agency Care:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services. • Physical therapy, occupational therapy, and speech therapy. • Medical social services. • Medical equipment and supplies. 	<p>There is no copayment for Medicare-covered home health visits.</p> <p><i>Prior authorization required.</i></p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p>Hospice care - For more information about hospice services, see Section 6.</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare. • Home care • Hospice consultation services (one time only) for a terminally ill individual who has not yet elected the hospice benefit. 	<p>You must receive care from a Medicare-certified hospice.</p> <p><i>Prior authorization required</i></p> <p>Hospice services in a Medicare-certified hospice are reimbursed directly by Medicare when you enroll in a Medicare-certified Hospice. (See Section 6 for more information about hospice services).</p>
OUTPATIENT SERVICES	
<p>Physician services, including doctor office visits</p> <ul style="list-style-type: none"> • Office visits, including medical and surgical care in a physician's office. • Certified ambulatory surgical center • Outpatient hospital services. • Consultation, diagnosis, and treatment by a specialist. • Second opinion by another plan provider prior to surgery. • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor). 	<p>You pay:</p> <ul style="list-style-type: none"> - \$15 for each primary care doctor office visit for Medicare-covered services. - \$100 copayment for each Medicare-covered ambulatory surgical center and \$100 copayment for each Medicare-covered Outpatient hospital services visit. <p><i>Prior authorization required</i> for ambulatory surgical center and outpatient hospital service visits.</p> <p>\$15 copayment for each Medicare-covered Consultation and certain Specialist visits.</p> <p><i>Prior authorization required</i> except for Self-referral to certain Group Health specialists at Group Health-operated medical centers only.</p>

Benefits chart – your covered services	What you must pay when you get these covered services
OUTPATIENT SERVICES	
Chiropractic services <ul style="list-style-type: none"> Manual manipulation of the spine to correct subluxation. 	<p>You pay \$15 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).</p> <p><i>Must use plan providers, no referral necessary for plan providers..</i></p> <p>You pay 100% for routine chiropractic services.</p>
Podiatry services <ul style="list-style-type: none"> Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). Routine foot care for members with certain medical conditions affecting the lower limbs. 	<p>You pay \$15 for each Medicare-covered visit (medically necessary foot care).</p> <p><i>Prior authorization required.</i></p> <p>You pay 100% for routine podiatry care.</p>
Outpatient mental health care (including Partial Hospitalization Services) Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. “Partial hospitalization” is a structured program of active treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.	<p>For Medicare-covered Mental Health services, you pay \$15 for each individual/group therapy visit.</p> <p>Self-referral to Group Health specialists only at Group Health-operated medical centers only.</p> <p><i>Prior authorization required for any services received at non-Group Health- operated medical centers.</i></p>

Benefits chart – your covered services	What you must pay when you get these covered services
Outpatient substance abuse services	<p>There is no copayment for each Medicare-covered visit.</p> <p>Self-referral to Group Health specialists at Group Health-operated medical centers only.</p> <p><i>Prior authorization required for any services received at non-Group Health-operated medical centers.</i></p>
Outpatient services/surgery	<p>You pay \$100 for each Medicare-covered visit to an ambulatory surgical center.</p> <p>You pay \$100 for each Medicare-covered visit to an outpatient hospital facility</p> <p><i>Prior authorization required.</i></p>
Ambulance services Includes ambulance services to an institution (like a hospital or SNF) from an institution to another institution, from an institution to your home, and services dispatched through 911, where other means of transportation could endanger your health.	<p>A \$75 co-payment per each one-way trip applies except; hospital to hospital ambulance transfers initiated by Group Health which are covered in full.</p>
Emergency care For more information see Section 3.	<p>You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 1 day for the same condition.</p> <p>Worldwide coverage.</p>
Urgently needed care For more information see Section 3.	<p>You pay \$15 for each Medicare-covered urgently needed care visit.</p> <p>Worldwide coverage.</p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p>Outpatient rehabilitation services (physical therapy, occupational therapy, cardiac rehabilitation, and speech and language therapy)</p> <p>Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris.</p>	<p>You pay \$15 for each Occupational Therapy, Physical Therapy and/or Speech/Language Therapy visit.</p> <p><i>Prior authorization required</i></p> <p>Medicare will limit how much it covers for certain therapy services starting January 1, 2006. For total physical and speech therapy services, Medicare will cover up to \$1,750 a year; For occupational therapy services Medicare will cover up to \$1,750 a year. These limits apply to outpatient therapy services provided in outpatient medical centers and skilled nursing facilities.</p>
<p>Durable medical equipment and related supplies</p> <p>Such as wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of “durable medical equipment” in Section 13)</p>	<p>You pay 20% of the cost for each Medicare-covered item.</p> <p><i>Prior authorization required.</i></p>
<p>Prosthetic devices and related supplies-- (other than dental) which replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” below for more detail.</p>	<p>You pay 20% of the cost for each Medicare-covered items.</p> <p><i>Prior authorization required.</i></p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p>Diabetes self-monitoring, training and supplies—for all people who have diabetes (insulin and non-insulin users).</p> <ul style="list-style-type: none"> • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors. • One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts. • Self-management training is covered under certain conditions. • <i>For persons at risk of diabetes:</i> Fasting plasma glucose tests. You may call the number on the cover of this booklet to contact GHC Customer Service for information on how often we will cover these tests. 	<p>There is no copayment for Diabetes self-monitoring training.</p> <p>You pay 20% of the cost for each Medicare-covered Diabetes supply item.</p> <p>A \$15 copayment applies for each separate office visit.</p> <p><i>Prior authorization required.</i></p>
<p>Medical nutrition therapy—for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.</p>	<p>A \$15 copayment applies for each separate office visit.</p> <p><i>Prior authorization required.</i></p>
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <ul style="list-style-type: none"> • X-rays. • Outpatient radiation therapy. • Surgical supplies, such as dressings. • Supplies, such as splints and casts. • Laboratory tests. • Blood- coverage of storage and administration begins with the first pint of blood that you need. 	<p>There is no copayment for Medicare-covered service(s):</p> <p>A \$15 copayment applies for each separate physician’s office visit.</p> <p><i>Prior authorization required.</i></p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p>Chemotherapy—Chemotherapy is covered when ordered by a GHC provider and all GHC referral protocol have been met. When providing care and services to Medicare Patients, GHC MUST use Medicare-certified providers and facilities.</p>	<p>A \$15 copayment applies for each separate office visit.</p> <p><i>Prior authorization required.</i></p>
PREVENTIVE CARE AND SCREENING TESTS	
<p>Bone mass measurements</p> <p><i>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary:</i> procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician’s interpretation of the results.</p>	<p>There is no copayment for Medicare-covered Bone Mass Measurement.</p> <p>A \$15 copayment applies for each separate office visit.</p> <p><i>Prior authorization required.</i></p>
<p>Colorectal screening</p> <p><i>For people 50 and older, the following are covered:</i></p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. <p><i>For people at high risk of colorectal cancer, the following are covered:</i></p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. <p><i>For people not at high risk of colorectal cancer, the following is covered:</i></p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy. 	<p>There is no copayment for Medicare-covered Colorectal Screening Exams.</p> <p>A \$15 copayment applies for each separate office visit.</p> <p><i>Prior authorization required.</i></p> <p>-\$100 copayment applies for each Medicare-covered ambulatory surgical center visit and a \$100 copayment applies for each Medicare-covered Outpatient hospital services visit.</p> <p><i>Prior authorization required for ambulatory surgical center and outpatient hospital service visits.</i></p>

Benefits chart – your covered services	What you must pay when you get these covered services
PREVENTIVE CARE AND SCREENING TESTS (cont.)	
<p>Immunizations</p> <ul style="list-style-type: none"> • Pneumonia vaccine (as explained in Section 2, you can get this service on your own, without a referral from your PCP as long as you get the service from a plan provider). • Flu shots, once a year in the fall or winter. As explained in Section 2, you can get this service on your own, without a referral from your PCP (as long as you get the service from a plan provider). • <i>If you are at high or intermediate risk of getting Hepatitis B:</i> Hepatitis B vaccine. • Other vaccines if you are at risk. 	<p>There is no copayment for the Pneumonia and Flu vaccines.</p> <p><i>No referral necessary for the Pneumonia and Flu vaccines.</i></p> <p>There is no copayment for the Hepatitis B vaccine.</p> <p>Immunizations and vaccines listed as covered in the GHC formulary</p>
<p>Mammography screening (as explained in Section 2, you can get this service on your own, without a referral from your PCP as long as you get it from a plan provider).</p> <ul style="list-style-type: none"> • One baseline exam between the ages of 35 and 39. • One screening every 12 months for women age 40 and older. 	<p>There is no copayment for Medicare-covered Screening Mammograms.</p> <p><i>No referral necessary for Medicare-covered screenings.</i></p> <p>A \$15 copayment applies for each separate office visit.</p>
<p>Pap smears, pelvic exams, and clinical breast exam (as explained in Section 2, you can get these routine women’s health services on your own, without a referral from your PCP (as long as you get the services from a plan provider)</p> <ul style="list-style-type: none"> • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months. • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months. 	<p>There is no copayment for Medicare-covered Pap Smears.</p> <p>A \$15 copayment applies for each separate office visit for Pelvic Exams.</p>

Benefits chart – your covered services	What you must pay when you get these covered services
PREVENTIVE CARE AND SCREENING TESTS (cont.)	
Prostate cancer screening exams <i>For men over age 50, the following are covered once every 12 months:</i> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	<p>There is no copayment for Medicare-covered Prostate Cancer Screening Exam.</p> <p>A \$15 copayment applies for each separate office visit.</p> <p><i>Prior authorization required.</i></p>
Cardiovascular screening blood tests Cholesterol and other lipid or triglyceride level blood tests for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). You may call the number on the cover of this booklet to contact GHC Customer Service for information on how often we will cover these tests.	<p>There is no copayment for Medicare-covered Cardiovascular screening blood tests.</p> <p>A \$15 copayment applies for each separate office visit.</p> <p><i>Prior authorization required</i></p>
OTHER SERVICES	
Renal Dialysis (Kidney) <ul style="list-style-type: none"> ▪ Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Sections 2 and 3). ▪ Inpatient dialysis treatments (if you are admitted to a hospital for special care). ▪ Self-dialysis training (includes training for you and for the person helping you with your home dialysis treatments). ▪ Home dialysis equipment and supplies. ▪ Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies when needed, and check your dialysis equipment and water supply). ▪ Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and Erythropoietin (Epogen ®) or Epoetin alfa, and Darbepoetin Alfa (Aranesp®). <i>Covered under Original Medicare.</i> 	<p>You are covered in full for each Medicare-covered visit.</p> <p><i>Prior authorization required except renal dialysis services out of the GHC MA Plan service area.</i></p>

Benefits chart – your covered services	What you must pay when you get these covered services
OTHER SERVICES	
<p>Prescription Drugs</p> <ul style="list-style-type: none"> • Drugs that are covered under Original Medicare (these drugs are covered for everyone with Medicare) <p>“Drugs” includes substances that are naturally present in the body, such as blood clotting factors.</p> <ul style="list-style-type: none"> • Drugs that usually are not self-administered by the patient and are injected while receiving physician services. • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by GHC. • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs if you have had an organ transplant that was covered by Medicare. • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Antigens. • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin alfa, and Darboetin Alfa (Aranesp®). • Intravenous Immune Globulin (IVIG) for treatment of primary immune deficiency diseases in the home: Medicare will pay for IVIG for the treatment of primary immune deficiency diseases in the beneficiary’s place of residence. 	<p>Most drugs not covered by Medicare. See Group outpatient prescription drug benefit.</p>

Benefits chart – your covered services	What you must pay when you get these covered services
ADDITIONAL BENEFITS	
<p>Dental services</p> <ul style="list-style-type: none"> Limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor. Dental benefits - dental care. 	<p>In general, you pay 100% for dental services.</p>
<p>Hearing services</p> <ul style="list-style-type: none"> Diagnostic hearing exams. Routine hearing exams Hearing aids. 	<p>There is no copayment for hearing aids up to 1 aid(s).</p> <p>You pay:</p> <p>\$15 for each Medicare-covered hearing exam (diagnostic hearing exams).</p> <p>\$ 0 for each routine hearing test up to 1 test(s) once every 24-months.</p> <p>\$ 0 for each fitting-evaluation for a hearing aid up to 1 fitting(s)-evaluation(s) once every 24-months.</p> <p>You are covered up to \$ 250 for hearing aids once every 24-months. Must use plan providers; <i>no referral necessary for plan providers.</i></p>

Benefits chart – your covered services	What you must pay when you get these covered services
ADDITIONAL BENEFITS	
<p>Vision care</p> <ul style="list-style-type: none"> • Outpatient physician services for eye care. • <i>For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans</i> who are age 50 and older: glaucoma screening once per year • One pair of standard eyeglasses or standard contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. • Routine eye exam once every 24 months. • Standard Glasses or Standard contacts once every 24 months. <p>Covered up to \$100 towards the purchase of frames once every 24 months.</p>	<p>There is no copayment for the following items:</p> <p>Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery).</p> <p>GHC Provides:</p> <ul style="list-style-type: none"> -Glasses, limited to 1 pair(s) of standard glasses covered up to UCR once every 24-months, or; -Contacts, limited to 1 pair(s) of standard contacts covered up to UCR once every 24-months. -\$15 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). -\$15 for each GHC-covered routine eye exam, limited to 1 exam(s) once every 24-months. <p>You are covered up to \$100 toward purchase of frames once every 24 months.</p> <p><i>Must use plan providers, no referral necessary for plan providers.</i></p>

Benefits chart – your covered services	What you must pay when you get these covered services
ADDITIONAL BENEFITS	
<p>One-time physical exam within 6 months of your first coverage under Part B</p> <p><i>For members whose Medicare Part B coverage begins on or after January 1, 2005, and who have not already taken advantage of this benefit in another plan or Original Medicare:</i></p> <p>A one-time physical exam within 6 months of your first coverage under Part B. Includes measurement of height, weight and blood pressure; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Does not include lab tests.</p>	<p>Please contact Group Health for further details.</p> <p>A \$15 copayment applies for the office visit for this one time physical exam.</p> <p><i>Must use plan providers, no referral necessary for plan providers.</i></p>
<p>Routine physical exams</p>	<p>There is no copayment for routine physical exams.</p> <p>You are covered up to 1 exam(s) every two years.</p> <p><i>Must use plan providers, no referral necessary for plan providers.</i></p>
<p>Health and wellness education programs</p> <ul style="list-style-type: none"> • Health Club Membership 	<p>You are covered in full for the following:</p> <p>Health Club Membership:</p> <p><u>SilverSneakers</u></p> <p>The SilverSneakers fitness program is part of your Group Health Medicare coverage. It's a fitness program designed with you in mind, and comes with a health club membership so you can keep yourself staying fit.</p> <p><i>For more information, call the Group Health Resource Line toll-free at 1-800-992-2279 or 206-326-2800, or the TTY line at 711 or 1-800-833-6388.</i></p>

(Continued)

- **Smoking & Tobacco Use Cessation Group Health Covered:**
- **Smoking & Tobacco Use Cessation Medicare Covered:**

Lifetime Fitness

Call the Group Health Resource Line toll-free at 1-800-992-2279, 206-326-2800 or Senior Services at 206-727-6259, or the TTY line at 711 or 1-800-833-6388 to find the participating Lifetime Fitness program facility nearest you.

Must use plan providers.

When member is enrolled and actively participating in the Free and Clear Program™, services provided through GHC related to smoking and tobacco use cessation are covered, limited to: Participation in one individual or group program per calendar year; One course of nicotine replacement therapy per calendar year; Educational materials covered in full.

Medicare will pay for two cessation-counseling attempts per year; each attempt includes 4 sessions each of either shorter visits of 3 to 10 minutes each, or longer visits (longer than 10 minutes each) depending on what the member and their doctor decide.

Must use plan providers

OTHER BENEFITS OFFERED BY THIS PLAN	
Transportation (routine)	A \$75 co-payment per each one-way trip applies. Limited to ambulance services only when medically necessary and authorized in advance by Group Health. All Group Health criteria must be met.
<p>Point of Service is available for the following benefits:</p> <ul style="list-style-type: none"> • Inpatient Hospital Care • Inpatient Mental Health Care • Skilled Nursing Facility • Home Health Care • Doctor Office Visits • Chiropractic Services • Podiatry Services • Outpatient Mental Health Care • Outpatient Substance Abuse Care • Outpatient Services/Surgery • Outpatient Rehabilitation Services • Durable Medical Equipment • Prosthetic Devices • Diabetes Self-Monitoring Training and Supplies • Diagnostic Tests, X-Rays, and Lab Services • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) • Pap Smears and Pelvic Exams • Prostate Cancer Screening Exams • Hearing Services • Vision Services • Comprehensive Outpatient Rehabilitation Facility (CORF) 	<p>Non-emergent and/or non-urgently needed care received while temporarily traveling outside GHC's Medicare Service Area is payable at Medicare benefit levels up to \$2,000 per member per calendar year. The GHC MA Plan pays 80% of Medicare allowable reimbursement schedules for Medicare covered services ONLY. Enrollee is responsible for all Medicare inpatient and outpatient deductibles and coinsurances</p> <p>You pay 20 % of the cost for each stay in a non-network hospital.</p> <p>You pay 20 % of the cost for each stay in a non-network Inpatient Psychiatric Hospital</p>

OTHER BENEFITS OFFERED BY THIS PLAN**Point of Service** (continued)

- Partial Hospitalization
- Other Health Care Professional Services
- Cardiac Rehabilitation Services
- Outpatient Blood

You pay 20 % of the cost for each stay in a non-network hospital.

You pay 20 % of the cost for each stay in a non-network Inpatient Psychiatric Hospital

Home Infusion Therapy Services:

Limited to Nursing Services, Medical Supplies, and Equipment. Prescription drugs are not covered.

OTHER BENEFITS OFFERED BY THIS PLAN**Skilled Nursing Facility** (Group Health Covered):

When a 3 day Medicare covered hospital stay does not occur and the plan determines that the member otherwise meets all Medicare criteria for an acute inpatient hospital stay at the time of admission to a Medicare certified Skilled Nursing Facility, the plan may authorize Medicare covered Skilled Nursing Facility Care up to the Medicare Skilled Nursing Facility day limit per benefit period. All Medicare criteria must be met and the stay must be authorized in advance by the plan.

Out-Of-Pocket Limit; Stop Loss Provision for Copayments:

Total copayment expenses for the following outpatient services are limited to an aggregate annual maximum of \$1000 per calendar year per member:

- Inpatient Hospital Care
- Inpatient Mental Health Care
- Doctor Office Visits

<p>Out-Of-Pocket Limit; Stop Loss Provision for Copayments: (Continued)</p>	<ul style="list-style-type: none"> • Chiropractic Services • Podiatry Services • Outpatient Mental Health Care • Outpatient Services/Surgery • Ambulance Services • Emergency Care • Urgently Needed Care • Outpatient Rehabilitation Services • Durable Medical Equipments • Prosthetic Devices • Diabetes Self Monitoring Training & Supplies • Diagnostic Tests, X-Rays, and Lab Services • Bone Mass Measurement • Colorectal Screening Exam • Mammograms (Annual Screenings) • Pap Smears and Pelvic Exams • Prostate Cancer Screening Exams • Hearing Services • Vision Services • Physical Exams • Transportation • Other Health Care Professionals • Cardiovascular Screening Blood Tests
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What if you have problems getting services you believe are covered for you?

If you have any concerns or problems getting the services that you believe are covered for you as a member, we want to help. Please call us at GHC Customer Service at the telephone number on the cover of this booklet. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered for you. See Section 9 for information about making a complaint.

Can your benefits change during the year?

The Medicare program has rules about when and how we can make changes in your benefits. **We can increase your benefits at any time during the calendar year** (the current calendar year is the period from January 1 through December 31, 2006). Here are some examples:

If we decide to add a new benefit, this would be an increase in your benefits (even though you might have to pay something if you use the new benefit).

- If we decide to provide more of some benefit that you already have, this would be an increase in your benefits.
- If we decide to reduce the amount of a copayment, coinsurance, or plan premium, this would also be an increase in your benefits because you would be getting the same benefits for less money.

If we decide to increase any of your benefits during the calendar year, we will let you know in writing.

The Medicare program does not allow us to decrease your benefits during the calendar year.

We are allowed to decrease your benefits only on January 1, at the beginning of the next calendar year. The Medicare program must approve any *decreases* we make in your benefits. We will tell you in advance (in October 2006) if there are going to be any increases or decreases in your benefits for the next calendar year that begins on January 1, 2007.

At any time during the year, the Medicare program can change its national coverage. Since we cover what Original Medicare covers, we would have to make any change that the Medicare program makes. These changes could be to increase or decrease your benefits, depending on what change the Medicare program makes. In some cases, if your benefits increase, Original Medicare will pay for the benefit for the rest of the calendar year. In those cases, you will have to pay Original Medicare out-of-pocket amounts for those services. We will let you know in advance if you will have to pay Original Medicare out-of-pocket amounts for an increased benefit.

Section 5 Medical care and services that are **NOT** covered (list of exclusions and limitations)

Introduction

The purpose of this section is to tell you about medical care and services that are not covered (“excluded”) or are limited by the GHC MA Plan. The list below tells about these exclusions and limitations. The list describes services that are not covered under *any* conditions, and some services that are covered only under specific conditions. (The Benefits Chart in Section 4 also explains about some restrictions or limitations that apply to certain services).

If you get services that are not covered, you must pay for them yourself

We will not pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will Original Medicare, unless they are found upon appeal to be services that we should have paid or covered (appeals are discussed in Sections 9 and 10).

What services are not covered by the GHC MA Plan?

In addition to any exclusions or limitations described in the Benefits Chart in Section 4, or anywhere else in this booklet, **the following items and services are not covered by the GHC MA Plan:**

1. Services that are not covered under Original Medicare, *unless* such services are specifically listed as covered by the GHC MA plan in Section 4.
2. Services that you get from non-plan providers, *except* for care for a medical emergency and urgently needed care, renal (kidney) dialysis services that you get when you are temporarily
3. outside the plan’s service area, and care from non-plan providers unless that care has been arranged or approved in advance by a plan provider. See other parts of this booklet (especially Sections 2 and 3) for information about using plan providers.
4. Services that you get without a referral from your plan provider, when a referral from your plan provider is required for getting that service.
5. Services that you get without prior authorization, when prior authorization is required for getting that service. (Section 4 gives a definition of prior authorization and tells which services require prior authorization.)
6. Services that are not reasonable and necessary under Original Medicare program standards unless otherwise listed as a covered service. The GHC MA Plan provides all covered services according to Medicare guidelines.
7. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency. (See Section 3 for more information about getting care for a medical emergency.)
8. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those items and procedures determined by Group Health and Original Medicare to not be generally accepted by the medical community. (See Section 6 for more information about participation in clinical trials while you are a member of the GHC MA plan.)
9. Surgical treatment of morbid obesity *unless* medically necessary and covered under Original Medicare.
10. Private room in a hospital, *unless* medically necessary.

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11. Private duty nurses.
 12. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
 13. Nursing care on a full-time basis in your home.
 14. The GHC MA Plan does not cover custodial care *unless* it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. “Custodial care” includes care that helps people with activities of daily living, like getting in and out of bed, bathing, using the bath room, dressing, walking, eating and preparation of special diets, and supervision of medication that is usually self-administered.
 15. Homemaker services.
 16. Charges imposed by immediate relatives or members of your household.
 17. Meals delivered to your home.
 18. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance, unless medically necessary.
 19. Cosmetic surgery or procedures, *unless* it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery and all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast, is covered.
 20. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. Certain dental services that you get when you are in the hospital will be covered.
 21. Chiropractic care is generally not covered under the plan, (with the exception of manual manipulation (subluxation) of the spine as outlined in Section 4,) and is limited according to Medicare guidelines.
 22. Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.
 23. Orthopedic shoes, *unless* they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, in the Benefits chart under “Outpatient Medical Services”.)
 24. Supportive devices for the feet. *There is an exception:* orthopedic or therapeutic shoes are covered for people with diabetic foot disease as described in 22 above.
 25. Radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
 26. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy.
 27. Reversal of sterilization procedures, sex change operations, and contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)
 28. Acupuncture.
 29. Naturopaths’ services.
 30. Services provided to veterans in Veteran’s Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, we will reimburse veterans for the difference between any excess VA cost sharing and cost sharing required under the GHC MA Plan. Members are still responsible for the GHC MA Plan cost sharing amount.
 31. The GHC MA plan does not offer a prescription drug benefit.
 32. Subrogation and Reimbursement Rights as specified in Section 7 of this Evidence of Coverage.

SECTION 6 Hospital care, skilled nursing facility care, and other services (this section gives additional information about some of the covered services that are listed in the Benefits Chart in Section 4)

Hospital care

If you need hospital care, we will arrange covered services for you. Covered services are listed in the Benefits Chart in Section 4 under the heading “Inpatient Hospital Care.” We use “hospital” to mean a facility that is certified by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic, and therapeutic services. The term “hospital” does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By “custodial care,” we mean help with using the bathroom, bathing, dressing, eating, and other activities of daily living.

See Section 13 for definition of Inpatient Care

What is a “benefit period” for hospital care?

The GHC MA Plan uses benefit periods to determine your coverage for inpatient services during a hospital stay (generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital). A “**benefit period**” begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility (SNF).

The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. (Later in this section we explain about SNF services).

What happens if you join or drop out of the GHC MA Plan during a hospital stay?

If you either join or leave the GHC MA Plan during an inpatient hospital stay, special rules apply to your coverage for the stay and to what you owe for this stay:

- **Coverage that ends during an inpatient stay.** GHC has no responsibility for payment of a Medicare Part A in-patient hospital stay that began prior to a member’s enrollment in the GHC MA-PD plan and ends after the enrollment in the GHC MA-PD Plan.

What is a “hospitalist”?

When you are admitted for a medically necessary procedure or treatment at a contracting GHC hospital, a physician who specializes in treating inpatients may coordinate your health care. These physicians are called hospitalists.

Skilled nursing facility care (SNF care)

If you need skilled nursing facility care, we will arrange these services for you. Covered services are listed in the Benefits Chart in Section 4 under the heading “Skilled nursing facility care.” The purpose of this subsection is to tell you more about some rules that apply to your covered services.

A skilled nursing facility is a **place that provides skilled nursing or skilled rehabilitation services** to help you recover after a hospital stay. It can be a separate facility, or part of a hospital or other health care facility. A skilled nursing facility is called a “SNF” for short.

The term “skilled nursing facility” does not include places that mainly provide custodial care, such as convalescent nursing homes or rest homes. (By “custodial care,” we mean help with using the bathroom, bathing, dressing, eating, and other activities of daily living.)

What is skilled nursing facility care?

“Skilled nursing facility care” means a level of care ordered by a physician that must be given or supervised by licensed health care professionals. It can be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise.

Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment such as how to use a walker or get in and out of a wheel chair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to do usual daily activities such as eating and dressing by yourself. Medicare will limit how much it covers for certain therapy services starting January 1, 2006. For total physical and speech therapy services, Medicare will cover up to \$1,750 a year; For occupational therapy services Medicare will cover up to \$1,750 a year. These limits apply to outpatient therapy services provided in outpatient medical centers and skilled nursing facilities.

To be covered, the care you get in a SNF must meet certain requirements

To be covered, you must need daily skilled nursing or skilled rehabilitation care, or both. If you do not need daily skilled care, other arrangements for care would need to be made. Note that medical services and other skilled care will still be covered when you start needing less than daily skilled care in the SNF.

Stays that provide custodial care only are not covered

“Custodial care” is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. The GHC MA Plan does not cover custodial care unless it is provided as other care you are getting *in addition to* daily skilled nursing care and/or skilled rehabilitation services.

There are benefit period limitations on coverage of skilled nursing facility care

Inpatient skilled nursing facility coverage is limited to usually 100 days each benefit period. A “**benefit period**” begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

In some situations, you may be able to get care in a SNF that is not a plan provider

Generally, you will get your skilled nursing facility care from SNFs that are plan providers for the GHC MA Plan. However, *if certain conditions are met*, you may be able to get your skilled nursing facility care from a SNF that is not a plan provider. One of the conditions is that the SNF that is not a plan provider must be willing to accept GHC rates for payment.

At your request, we may be able to arrange for you to get your skilled nursing facility care from one of the facilities listed below (in these situations, the facility is called a “Home SNF”):

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as the place gives skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

What happens if you join or drop out of the GHC MA Plan during a SNF stay?

If you either join or leave the GHC MA Plan during a SNF stay, special rules apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call GHC Customer Service at the telephone number listed on the cover of this booklet. GHC Customer Service can explain how your services are covered for this stay, and what you owe to GHC, if any, for the periods of your stay when you were and were not a plan member.

Home health agency care

Home health care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 4 under the heading “Home health care.” If you need home health care services, we will arrange these services for you if the requirements described below are met.

What are the requirements for getting home health agency services?

To get home health agency care benefits, you must meet all of these conditions:

1. You must be **home-bound**. This means that you are normally unable to leave your home and that leaving home is a major effort. When you leave home, it must be to get medical treatment or be infrequent, for a short time. You may attend religious services. You can also get care in an adult day care program that is licensed or certified by a state or accredited to furnish adult day care services in a state.

Occasional absences from the home for non-medical purposes, such as an occasional trip to the barber or a walk around the block or a drive, would not mean that you are not homebound if the absences are on infrequent or are of relatively short duration. The absences cannot indicate that you have the capacity to obtain the health care provided outside of your home.

Generally speaking, you will be considered to be homebound if you have a condition due to an illness or injury that restricts your ability to leave your home except with the aid of supportive devices or if leaving home is medically contraindicated. “Supportive devices” include crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person.

2. Your doctor must decide that you need medical care in your home, and must make a plan for your care at home. Your **plan of care** describes the services you need, how often you need them, and what type of health care worker should give you these services.
3. The home health agency caring for you must be approved by the Medicare program.

4. You must need *at least one* of the following types of skilled care:

- Skilled nursing care on an “intermittent” (not full time) basis. Generally, this means that you must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days. Skilled nursing care includes services that can only be performed by or under the supervision of a licensed nurse.
- Physical therapy, which includes exercise to regain movement and strength to an area of the body, and training on how to use special equipment or do daily activities such as how to use a walker or get in and out of a wheel chair or bathtub.
- Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.
- Continuing occupational therapy, which helps you learn how to do usual daily activities by yourself. For example, you might learn new ways to eat or new ways to get dressed.

Home health care can include services from a home health aide, as long as you are also getting skilled care

As long as some qualifying skilled services are *also* included, the home health care you get can include services from a home health aide. A home health aide does not have a nursing license. The home health aide provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care such as bathing, using the toilet, dressing, or carrying out the prescribed exercises. The services from a home health aide must be part of the home care for your illness or injury, and they are not covered unless you are *also* getting a covered skilled service. Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

What are “part time” and “intermittent” home health care services?

If you meet the requirements given above for getting covered home health services, you may be eligible for “part time” or “intermittent” skilled nursing services and home health aide services:

- **“Part-time” or “Intermittent”** means your skilled nursing and home health aide services combined total less than 8 hours per day and 35 or fewer hours each week.

Hospice care for people who are terminally ill

“Hospice” is a special way of caring for people who are terminally ill, and for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients make the most of the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

Terminally ill members who have not yet elected the hospice benefit are covered for a one-time hospice consultation service that may include evaluations of the patient’s need for pain management, symptom management, and care options.

As a member of the GHC MA Plan, you may receive care from any Medicare-certified hospice. Your doctor can help you arrange for your care in a hospice. If you are interested in using hospice services, you can call GHC Customer Service at the number on the cover of this booklet to get a list of the Medicare-certified hospice providers in your area, or you can call the Regional Home Health Intermediary (RHHI) for Washington State at: 1-877-602-7904. You can write to RHHI at: United Government Services, P.O. Box 9140, Oxnard, CA 93031-9140 or visit the RHHI website at www.ugsmedicare.com.

If you enroll in a Medicare-certified hospice, Original Medicare (rather than the GHC MA Plan) pays the hospice for the hospice services you receive. Your hospice doctor can be a plan provider or a non-plan provider. If you choose to enroll in a Medicare-certified hospice, you are still a plan member and continue to get the rest of your care that is unrelated to your terminal condition through the GHC MA Plan. If you use non-plan providers for your routine care, Original Medicare (rather than the GHC MA Plan) will cover your care and you will have to pay Original Medicare out-of-pocket amounts.

The Medicare program has written a booklet about “Medicare Hospice Benefits.” To get a free copy call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), which is the national Medicare help line, or visit the Medicare website at www.medicare.gov. Section 1 tells more about how to contact the Medicare program and about the website.

Organ transplants

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others are not). The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, pancreas (when performed with or after a Medicare-covered kidney transplant), liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. Please be aware that the following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

Participating in a clinical trial

A “clinical trial” is a way of testing new types of medical care, like how well a new cancer drug works. Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose, or treat diseases. The trials help doctors and researchers see if a new approach works and if it is safe. There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, Original Medicare (and not the GHC MA Plan) pays the clinical trial doctors and other providers for the covered services you receive that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in the GHC MA Plan and continue to get the rest of your care that is unrelated to the clinical trial through the GHC MA Plan. You will have to pay the Original Medicare coinsurance for clinical trial services.

The Medicare program has written a booklet about “Medicare and Clinical Trials.” To get a free copy, call 1-800 –MEDICARE (1-800-633-4227) or visit www.medicare.gov on the web. Section 1 tells more about how to contact the Medicare program and about Medicare’s website.

You do *not* need to get a referral from a plan provider to join a clinical trial, and the clinical trial providers do *not* need to be plan providers. However, please be sure **to tell us before you start a clinical trial** so that we can keep track of your health care services. When you tell us about starting a clinical trial, we can let you know what services you will get from clinical trial providers.

Care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) or Medicare-certified RNHCI services furnished in the home (but only with respect to items and services ordinarily furnished by home health agencies that are not RNHCI) are covered by the GHC MA Plan under certain conditions. Medicare Covered services in a RNHCI or RNHCI services furnished in the home are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI or RNHCI services furnished in the home, you must have a medical condition that would allow you to receive inpatient hospital care or extended care services, or care from a home health agency. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of “nonexcepted” medical treatment. (“Excepted” medical treatment is medical care or treatment that you receive involuntarily or that is required under Federal, State or local law. “Nonexcepted” medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from the GHC MA Plan, or your stay in the RNHCI or RNHCI services furnished in the home may not be covered.

SECTION 7 What you must pay for your Medicare health plan coverage and for the care you receive

Paying the plan premium for your coverage as a member of the GHC MA plan

To be a member of the GHC MA Plan, you must continue to pay your Medicare Part B premium. If you have to pay a Medicare Part A premium (most people do not), you must continue paying that premium to be a member. You also have the GHC MA Plan premiums that you must pay.

How much is your monthly plan premium and how do you pay it?

In the GHC MA Plan, **you must pay a \$83 premium each month**. This monthly plan premium covers your basic benefits.

The GHC MA Plan offers two methods for paying your monthly plan premiums.

You can use one of these methods to pay your plan premium for basic benefits and any other premiums that you may owe GHC, such as premiums for the GHC MA Plan Part A Equivalent Benefit Premium. These methods for paying your premiums are:

1. You may receive a monthly, quarterly or annual billing statement; or
2. You can pay by automatic deduction from your checking or savings account.

If you are interested in the Automatic Payment Plan (APP), please call GHC Customer Service and ask for an application.

If you have any questions about your plan premiums or the payment programs you can use, please call GHC Customer Service at the number on the cover of this booklet, Monday-Friday, 8:00 a.m. to 5:00 p.m.

What happens if you don't pay your plan premiums, or don't pay them on time?

If your plan premiums are past due, we will tell you in writing when a 60-day grace period begins. If you do not pay your past-due plan premiums within the 60-day grace period, we will disenroll you. Disenrolling you ends your membership in the GHC MA Plan. You will then have Original Medicare coverage (Section 11 explains about disenrollment and Original Medicare coverage). Should you decide later to re-enroll in the GHC MA Plan, or to enroll in another plan offered by GHC, you will have to pay any past-due plan premiums that you still owe from your previous enrollment in the GHC MA Plan.

Can your plan premiums change during the year?

We are allowed to *decrease* your plan premium at any time during the calendar year, but we are not allowed to increase it (the current calendar year is the period from January 1, 2006 through December 31, 2006). If we decide to decrease your plan premium during the calendar year, we will let you know in writing. **Increases in your plan premium are only allowed at the beginning of each calendar year, and must be approved by Medicare.** We will tell you in advance if there will be any changes for the next calendar year in your plan premiums or in the amounts you will have to pay when you get covered services. If there are any changes for the next calendar year, they will take effect on January 1, 2006.

Paying your share of the cost when you get covered services

What are “deductibles”, “copayments” and “coinsurance”?

- The **“Deductible”** is the amount you must pay for the health care services you receive, before GHC begins to pay its share of your covered services.
- **“Copayment”** is a payment you make for your share of the cost of certain covered services you receive. A copayment is **a set amount per service** (such as paying \$ 15 for a doctor visit). You pay it when you get the service. The Benefits Chart in Section 4 gives your copayments for covered services.
- **“Coinsurance”** is a payment you make for your share of the cost of certain covered services you receive. Coinsurance is **a percentage of the cost of the service** (such as paying 20% for a Point of Service benefit). You pay your coinsurance when you get the service. The Benefits Chart in Section 4 gives your coinsurance for covered services.

What is the most you will pay for covered care?

There is a limit to how much you will have to pay for your covered health care each year.

During the year, if the amount that you spend on your copayments as a member of the GHC MA Plan goes over an aggregate amount of \$1,000 per calendar year, we will begin to pay for all of your covered health care.

Total copayment expenses for the following services are limited to an aggregate annual maximum of \$1,000 per calendar year per member: Inpatient Hospital Care, Inpatient Mental Health Care, Doctor Office Visits, Chiropractic Services, Podiatry Services, Outpatient Mental Health Care, Outpatient Services/Surgery, Ambulance Services, Emergency Care, Urgently Needed Care, Outpatient Rehabilitation Services, Durable Medical Equipment, Prosthetic Devices, Diabetes Self-Monitoring

Training and Supplies, Diagnostic Tests, X-Rays, and Lab Services, Bone Mass Measurement, Colorectal Screening Exam, Mammograms (Annual Screenings), Pap Smears and Pelvic Exams, Prostate Cancer Screening Exams, Hearing Services, Vision Services, Physical Exams, Transportation, Other Health Care Professional and Cardiovascular Screening Blood Tests.

You must pay the full cost of services that are not covered

You are personally responsible to pay for care and services that are not covered by the GHC MA Plan. Other sections of this booklet tell about covered services and the rules that apply to getting your care as a plan member. With few exceptions, you must pay for services you receive from providers who are not part of the GHC MA Plan unless GHC has approved these services in advance. The exceptions are care for a medical emergency, urgently needed care, out-of-area renal (kidney) dialysis services and services that are found upon appeal to be services that we should have paid or covered. (Sections 2 and 3 explain about using plan providers and the exceptions that apply.)

Please keep us up-to-date on any other health insurance coverage you have

Using *all* of your insurance coverage

If you have other health insurance coverage besides the GHC MA Plan, it is important to use this other coverage *in combination with* your coverage as a member to pay for the care you receive. This is called “coordination of benefits” because it involves *coordinating* all of the health *benefits* that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

Subrogation and Reimbursement Rights

“Injured Person” under this section means a Member covered by the Agreement who sustains compensable injury and any spouse, dependent, or other person or entity that may recover on behalf of such Member, including the estate of the Member and, if the Member is a minor, the guardian or parent of the Member. When referred to in this section, “GHC’s Medical Expenses” means the expense incurred and the reasonable value of the services provided by GHC for the care or treatment of the injury sustained by the Injured Person.

If the Injured Person’s injuries were caused by a third party giving rise to a claim of legal liability against the third party and/or payment by the third party to the Injured Person and/or a settlement between the third party and the Injured Person, GHC shall have the right to recover GHC’s Medical Expenses from any source available to the Injured Person as a result of the events causing the injury, including but not limited to funds available through applicable third party liability coverage and uninsured/underinsured motorist coverage. This right is commonly referred to as “subrogation.” GHC shall be subrogated to and may enforce all rights of the Injured Person to the extent of GHC’s Medical Expenses.

If the Injured Person is entitled to or does receive money from any source as a result of the events causing the injury, including but not limited to any party’s liability insurance or uninsured/underinsured motorist funds, then GHC’s Medical Expenses provided or to be provided to the Injured Person are secondary, not primary, and will be paid only if the Injured Person fully cooperates with the terms and conditions of the Agreement. As a condition of receiving benefits under the Agreement, the Injured Person agrees that acceptance of GHC services is constructive notice of this provision in its entirety and

agrees to reimburse GHC for the benefits the Injured Person received as a result of the events causing the injury. GHC's right of subrogation shall be the full amount of GHC's Medical Expenses and is limited only as required by Medicare.

The Injured Person and his/her agents shall cooperate fully with GHC in its efforts to collect GHC's Medical Expenses. This cooperation shall include supplying GHC with information about any defendants and/or insurers related to the Injured Person's claim. The Injured Person and his/her agents shall permit GHC, at GHC's option, to associate with the Injured Person or to intervene in any legal, quasi-legal, agency or any other action or claim filed. If the Injured Person takes no action to recover money from any source, then the Injured Person agrees to allow GHC to initiate its own direct action from the Injured Person for reimbursement or subrogation, including, but not limited to, billing the Injured Person directly for GHC's Medical Expenses.

The Injured Person and his/her agents shall do nothing to prejudice GHC's subrogation and reimbursement rights. The Injured Person shall promptly notify GHC of any tentative settlement with a third party and shall not settle a claim without protecting GHC's interest. If the Injured Person fails to cooperate fully with GHC in recovery of GHC's Medical Expenses, the Injured Person shall be responsible for directly reimbursing GHC for GHC's Medical Expenses.

To the extent that the Injured Person recovers funds from any source, the Injured Person agrees to hold such monies in trust or in their possession until GHC's subrogation and reimbursement rights are fully determined.

GHC shall not pay any attorney's fees or collection costs to attorneys representing the Injured Person unless there is a written fee agreement signed by GHC prior to any collection efforts. When reasonable collection costs have been incurred with GHC's prior written agreement to recover GHC's Medical Expenses, there shall be an equitable apportionment of such collection costs between GHC and the Injured Person subject to a maximum responsibility of GHC equal to one-third of the amount recovered on behalf of GHC. Under no circumstance will GHC pay legal fees for services which were not reasonably and necessarily incurred to secure recovery and/or which do not benefit GHC.

If it becomes necessary for GHC to enforce the provision of this section by initiating any action against the Injured Person or his/her agent, then the Injured Person agrees to pay GHC's attorney's fees and costs associated with the action.

Implementation of this section shall be deemed a part of claims administration under the Agreement and GHC shall therefore have sole discretion to interpret its terms.

Let us know if you have additional insurance

You must tell us if you have any other health insurance coverage besides the GHC MA Plan, and let us know whenever there are any *changes* in your additional insurance coverage. The types of additional insurance you might have include the following:

- Coverage that you have from an employer's group health insurance for *employees or retirees*, either through yourself or your spouse.
- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program.
- Coverage you have for an accident where no-fault insurance or liability insurance is involved.

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- Coverage you have through Medicaid.
 - Coverage you have through the “TRICARE for Life” program (veteran’s benefits).
 - Coverage you have for dental insurance or prescription drugs.
 - “Continuation coverage” that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions).

Who pays first when you have additional insurance?

When you have additional insurance coverage, how we coordinate your benefits as a member the GHC MA Plan with your benefits from other insurance depends on your situation. With coordination of benefits, you will often get your care as usual through the GHC MA Plan, and the other insurance you have will simply help pay for the care you receive. In other situations, such as for benefits that are not covered by the GHC MA Plan you may get your care outside of the GHC MA Plan, however, the GHC MA Plan has no obligation to provide payment for any services not covered or not referred by the Plan.

In general, the insurance company that pays its share of your bills *first* is called the “**primary payer.**” Then the other company or companies that are involved—called the “**secondary payers**”—each pay their share of what is left of your bills. Often your other insurance company will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this payment to us. When you have additional health insurance, **whether we pay first or second—or at all—depends on what type or types of additional insurance you have and the rules that apply to your situation.** Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have End-Stage Renal Disease (permanent kidney failure), or how many employees are covered by an employer’s group insurance.

If you have additional health insurance, please call GHC Customer Service at the phone number on the cover of this booklet to find out which rules apply to your situation, and how payment will be handled. Also, the Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance. It’s called *Medicare and Other Health Benefits: Your Guide to Who Pays First*. You can get a copy by calling 1-800-MEDICARE (1-800-633-4227, TTY 1-877-486-2048), or by visiting the www.medicare.gov website.

What should you do if you have bills from non-plan providers that you think we should pay?

As explained in Sections 2 and 3, we cover certain health care services that you get from non-plan providers. These include care for a medical emergency, urgently needed care, renal dialysis that you get when you are outside the plan’s service area, care that has been approved in advance by a plan provider and services that we denied but that were overturned in an appeal. If a non-plan provider asks you to pay for covered services you get in these situations, please contact us at GHC Claims Administration, P. O. Box 34585, Seattle WA 98124-1585. It is best to ask a non-plan provider to bill us first, but if you have already paid for the covered services we will reimburse you for our share of the cost. If you received a bill for the services, you can send the bill to us for payment. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. You will not have to pay a non-plan provider any more than what he or she would have received from you if you had been covered with Original Medicare.

Section 8 Your rights and responsibilities as a member of the GHC MA Plan

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this first part of Section 8, we explain your Medicare rights and protections as a member of the GHC MA Plan. Then, after we have explained your rights, we tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048). You can call 24 hours a day, 7 days a week.

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. GHC must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability you may have. If you need help with communication, such as help from a language interpreter, please call GHC Customer Service at the number on the cover of this booklet. GHC Customer Service can also help if you need to file a complaint about access (such as wheel chair access). You can also call the Office of Civil Rights at 1-800-368-1019, or TTY/TDD 1-800-537-7697, or call the Office of Civil Rights in your area.

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We keep your personal health information private as protected under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care.

There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask plan providers to make additions or corrections to your medical records (if you ask plan providers to do this, they will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call GHC Customer Service at the phone number on the cover of this booklet.

Your right to see plan providers and get covered services within a reasonable period of time

As explained in this booklet, you will get most or all of your care from plan providers, that is, from doctors and other health providers who are part of the GHC MA Plan. You have the right to choose a plan provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health specialist (such as a gynecologist) without a referral. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. You also have the right to timely access to your prescriptions at any network pharmacy. "Timely access" means that you can get appointments and services within a reasonable amount of time. Section 2 explains how to use plan providers to get the care and services you need. Section 3 explains your rights to get care for a medical emergency and urgently needed care.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment choices that are recommended for your condition, no matter what they cost or whether they are covered by the GHC MA Plan. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a plan provider has denied care that you believe you are entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision. "Initial decisions" are discussed in Sections 9 and 10.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "**advance directives.**" There are different types of advance directives and different names for them. Documents called "**living will**" and "**durable power of attorney for health care**" are examples of advance directives.

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as SHIBA (which stands for Statewide Health Insurance Benefits Advisors). Section 1 of this booklet tells how to contact SHIBA. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have *not* signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is *your choice* whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you *have* signed an advance directive, and you believe that a doctor or hospital has not followed the instructions in it, you may file a complaint with SHIBA at the Washington State Office of the Insurance Commissioner by writing to SHIBA HelpLine, Office of the Insurance Commissioner, P.O. Box 40256, Olympia, WA 98504-0256, or calling the 24-hour toll-free SHIBA Helpline at 1-800-397-4422, TTY/ TDD 1-800-664-3154, or Fax (360)-407-0349.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. “Appeals” and “grievances” are the two different types of complaints you can make. Which one you make depends on your situation. Appeals are discussed in Sections 9 and 10, and grievances are discussed in Section 9.

If you make a complaint, we must treat you fairly (i.e., not discriminate against you) because you made a complaint.

You have the right to get a summary of information about the appeals and grievances that members have filed *against* GHC in the past. To get this information, call GHC Customer Service at the phone number on the cover of this booklet.

Your right to get information about your health care coverage and costs

This booklet tells you what medical services are covered for you as a plan member and what you have to pay. If you need more information, please call GHC Customer Service at the number on the cover of this booklet. You have the right to an explanation from us about any bills you may get for services not covered by the GHC MA Plan. We must tell you in writing why we will not pay for or allow you to get a service, and how you can file an appeal to ask us to change this decision. See Sections 9 and 10 for more information about filing an appeal.

Your right to get information about GHC, the GHC MA Plan, and plan providers

You have the right to get information from us about GHC and the GHC MA Plan. This includes information about our financial condition, about our health care providers and their qualifications, and about how the GHC MA Plan compares to other health plans. You have the right to find out from us how we pay our doctors. To get any of this information, call GHC Customer Service at the phone number on the cover of this booklet.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call GHC Customer Service at the number on the cover of this booklet. You can also get free help and information from SHIBA your Statewide Health Insurance Benefits Advisors (Section 1 tells how to contact SHIBA in Washington state). In addition, the Medicare program has written a booklet called *Your Medicare Rights and Protections*. To get a free copy, call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048). Or you can visit the Medicare website at www.medicare.gov to order this booklet or print it directly from your computer.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, what you should do depends on your situation.

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. Or, you can call the Office for Civil Rights in your area at 1-800-368-1019 or TTY at 1-800-537-4697 (If you have a hearing or speech impairment).
- For any other kind of concern or problem related to your Medicare rights and protections described in this section, you can call GHC Customer Service at the number on the cover of this booklet.

You can also get help from SHIBA your Statewide Health Insurance Benefits Advisors (Section 1 tells how to contact SHIBA in Washington state).

What are your responsibilities as a member of the GHC MA Plan?

Along with the rights you have as a member of the GHC MA Plan you also have some responsibilities. Your responsibilities include the following:

- To get familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet and any amendments we send you to learn about your coverage, what you have to pay, and the rules you need to follow. Please call GHC Customer Service at the phone number on the cover of this booklet if you have any questions.

- To give your doctor and other providers the information they need to care for you, and to follow the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions.
- To act in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- To pay your plan premiums and any copayments you may owe for the covered services you get. You must also meet your other financial responsibilities that are described in Section 7 of this booklet.
- To let us know if you have any questions, concerns, problems, or suggestions. If you do, please call GHC Customer Service at the phone number on the cover of this booklet.

SECTION 9 Appeals and grievances: what to do if you have complaints

Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your covered services or the care you receive. Please call GHC Customer Service at the number on the cover of this booklet.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint, and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from the GHC MA Plan or penalized in any way if you make a complaint.

What are appeals and grievances?

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make.

- An **"appeal"** is the type of complaint you make **when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service**. For example, if we refuse to cover or pay for services you think we should cover, you can file an appeal. If GHC or one of our plan providers refuses to give you a service you think should be covered, you can file an appeal. If GHC or one of our plan providers reduces or cuts back on services you have been receiving, you can file an appeal. If you think we are stopping your coverage of a service too soon, you can file an appeal.
 - A **"grievance"** is the type of complaint you make **if you have any other type of problem with GHC, the GHC MA Plan, or one of our plan providers**. For example, you would file a grievance if you have a problem with things such as the quality of your care, waiting times for
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appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office.

This section tells how to make complaints in different situations

The rest of this section has separate parts that tell you how to make a complaint in each of the following situations:

1. **Complaints about what we will cover for you or what we will pay for.** If GHC or your doctor or another plan provider has refused to give you a service you think is covered, you can make a complaint called an **appeal**. If we have refused to pay for a service you think is covered for you, you can make an appeal. If you have been receiving a covered service, and you think that service is being reduced or ending too soon, you can make an appeal. When you file an appeal, you are asking us to reconsider and change a decision we have made about what services we will cover for you (which includes whether we will pay for your care or how much we will pay).
2. **Complaints if you think you are being discharged from the hospital too soon.** There is a special type of **appeal** that applies only to **hospital discharges**. If you think our coverage of your hospital stay is ending too soon, you can appeal directly and immediately to Qualis Health which is the Quality Improvement Organization (QIO) in the State of Washington. Qualis Health is a group of health professionals in Washington State that is paid to handle this type of appeal from Medicare patients. If you make this type of appeal, your stay may be covered during the time period that Qualis Health uses to make its determination. You must act very quickly to make this type of appeal, and it will be decided quickly.
3. **Complaints if you think your coverage for Skilled Nursing Facility (SNF), Home Health (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.** There is another special type of **appeal** that applies only to when coverage will end for **SNF, HHA or CORF** services. If you think your coverage is ending too soon, you can appeal directly and immediately to Qualis Health, which is the Quality Improvement Organization in the State of Washington. If you make this type of appeal, your stay may be covered during the time period the QIO uses to make its determination. You must act very quickly to make this type of appeal, and it will be decided quickly.
4. **Complaints about any other type of problem you have with GHC, GHC MA Plan, or one of our plan providers.** If you want to make a complaint about any type of problem other than those that are listed above, a **grievance** is the type of complaint you would make. For example, you would file a grievance to complain about problems with the quality or timeliness of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office. Generally, you would file the grievance with GHC. But for many problems related to quality of care you get from plan providers, you can also complain to Qualis Health, the QIO in Washington State.

PART 1. Complaints (appeals) to GHC to change a decision about what we

will cover for you or what we will pay for

This part of Section 9 explains what you can do if you have problems getting the medical care you believe we should provide.

We use the word “provide” in a general way to include such things as authorizing care, paying for care, arranging for someone to provide care, or continuing to provide a medical treatment you have been getting. Problems getting the medical care you believe we should provide include the following situations:

- If you are not getting the care you want, and you believe that this care is covered by the GHC MA Plan.
- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by the GHC MA Plan.
- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health.
- If you have received care that you believe was covered by the GHC MA Plan while you were a member, but we have refused to pay for this care.

Six possible steps for requesting care or payment from the GHC MA Plan

If you are having a problem getting care or payment for care, there are six possible steps you can take to ask for the care or payment you want from us. At each step, your request is considered and a decision is made. If you are unhappy with the decision, there may be another step you can take if you want to continue requesting the care or payment.

- In Steps 1 and 2, you make your request directly to us. We review it and give you our decision.
- In Steps 3 through 6, people in organizations that are not connected to us make the decisions about your request. To keep the review independent and impartial, those who review the request and make the decision in Steps 3 through 6 are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

The six possible steps are summarized below (they are covered in more detail in Section 10).

STEP 1: The initial decision by GHC

The starting point is when we make an “initial decision” (also called an “organization determination”) about your medical care or about paying for care you have already received. When we make an “initial decision,” we are giving our interpretation of how the benefits and services that are covered for members of the GHC MA Plan apply to your specific situation. As explained in Section 10, you can ask for a “fast initial decision” if you have a request for medical care that needs to be decided more quickly than the standard time frame.

STEP 2: Appealing the initial decision by GHC

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an “**appeal**” or a “request for reconsideration.” As explained in Section 10, you can ask for a “fast appeal” if your request is for medical care and it needs to be decided more quickly than the

standard time frame. After reviewing your appeal, we will decide whether to stay with our original decision, or change this decision and give you some or all of the care or payment you want.

STEP 3: Review of your request by an Independent Review Organization

If we turn down part or all of your request in Step 2, we are **required** to send your request to an independent review organization that has a contract with the federal government and is not part of GHC. This organization will review your request and make a decision about whether we must give you the care or payment you want.

STEP 4: Review by an Administrative Law Judge

If you are unhappy with the decision made by the organization that reviews your case in Step 3, you may ask for an **Administrative Law Judge** to consider your case and make a decision. The Administrative Law Judge works for the federal government. The dollar value of your medical care must be at least \$110 to be considered in Step 4.

STEP 5: Review by a Medicare Appeals Council

If you or we are unhappy with the decision made in Step 4, either of us may be able to ask a **Medicare Appeals Council** to review your case. This Council is part of the federal department that runs the Medicare program.

STEP 6: Federal Court

If you or we are unhappy with the decision made by the Medicare Appeals Council in Step 5, either of us may be able to take your case to a Federal Court. The dollar value of your contested medical care must be at least \$1,090 to go to a Federal Court.

For a more detailed explanation of all six steps outlined above, see Section 10.

PART 2. Complaints (appeals) if you think you are being discharged from the hospital too soon

When you are hospitalized, you have the right to get all the hospital care covered by the GHC MA Plan that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your “discharge date”) is based on when your stay in the hospital is no longer medically necessary. This part of Section 9 explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

When you are admitted to the hospital, someone at the hospital should give you a notice called the *Important Message from Medicare*. This notice explains your rights under the law.

When a doctor decides that you are ready to leave the hospital (to “be discharged”), you should be given a copy of another notice that includes specific information about your hospital discharge. This other notice is called the *Notice of Discharge and Medicare Appeal Rights*.

These notices will tell you:

- Your right to get all medically necessary hospital services covered.
- Your right to know about any decisions that the hospital, your doctor, or anyone else makes about your hospital stay and who will pay for it.
- That your doctor or the hospital may arrange for services you will need after you leave the hospital.
- Your right to appeal a discharge decision.

As a member of the GHC MA Plan, you should receive this information about your discharge *before* you leave the hospital. You (or someone you authorize) may be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the hospital – it only means that you received the notice. If you do not receive the notice when you are being told about your discharge from the hospital, be sure to ask for it immediately.

Review of your hospital discharge by the Quality Improvement Organization

If you think that you are being discharged too soon, you must ask your health plan to give you a notice called the *Notice of Discharge & Medicare Appeal Rights*. This notice will tell you:

- Why you are being discharged.
- The date that we will stop covering your hospital stay (stop paying our share of your hospital costs).
- What you can do if you think you are being discharged too soon.
- Who to contact for help.

You (or someone you authorize) may be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the hospital – it only means that you received the notice. If you do not get the notice after you have said that you think you are being discharged too soon, be sure to ask for it immediately.

You have the right by law to ask for a review of your discharge date. As explained in *the Notice of Discharge & Medicare Appeal Rights*, if you act quickly, you can ask an outside agency called the Quality Improvement Organization to review whether your discharge is medically appropriate.

What is the “Quality Improvement Organization”?

“QIO” stands for **Q**uality **I**mprovement **O**rganization.

The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of GHC or your hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. In Washington State the QIO is called Qualis Health. The doctors and other health experts in Qualis Health/the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon. Section 1 tells how to contact the QIO.

Getting a QIO review of your hospital discharge

If you want to have your discharge reviewed, you must act quickly to contact the QIO. The *Notice of Discharge & Medicare Appeal Rights* gives the name and telephone number of your QIO and tells you what you must do.

- You must ask the QIO for a “**fast review**” of whether you are ready to leave the hospital. This “fast review” is also called a “fast appeal” because you are appealing the discharge date that has been set for you.
- You must be sure that you have made your request to the QIO **no later than noon** on the first working day after you are given written notice that you are being discharged from the hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the hospital past your discharge date without paying for it yourself, while you wait to get the decision from the QIO (see below).

If the QIO reviews your discharge, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. The QIO will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

- If the QIO decides that your discharge date was medically appropriate, you will not be responsible for paying the hospital charges until noon of the calendar day after the QIO gives you its decision.
- If the QIO agrees with you, then we will continue to cover your hospital stay for as long as medically necessary.

What if you do not ask the QIO for a review by the deadline?

You still have another option: asking GHC for a “fast appeal” of your discharge

If you do not ask the QIO for a “fast review” (“fast appeal”) of your discharge by the deadline, you can ask us for a “fast appeal” of your discharge. How to ask us for a fast appeal is covered briefly in the first part of this section and in more detail in Section 10.

If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you run the risk of having to pay for the hospital care you receive past your discharge date.

Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care for as long as medically necessary.
- If we decide that you should not have stayed in the hospital beyond your discharge date, then we will **not** cover any hospital care you received if you stayed in the hospital after the discharge date.

You may have to pay if you stay past your discharge date

If you stay in the hospital after your discharge date and do not ask for immediate QIO review, you may be financially responsible for the cost of many of the services you receive. However, you can appeal any bills for hospital care you receive, using Step 1 of the appeals process described in Section 10.

PART 3. Complaints(appeals) if you think your coverage for SNF, home health or comprehensive outpatient rehabilitation facility services is ending too soon.

When you are a patient in a SNF, Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), you have the right to get all the SNF, HHA or CORF care covered by the GHC MA Plan that is necessary to diagnose and treat your illness or injury. The day we end your SNF, HHA or CORF coverage is based on when your stay is no longer medically necessary. This part of Section 9 explains what to do if you believe that your coverage is ending too soon.

Information you will receive during your SNF, HHA or CORF stay

If we decide to end our coverage for your SNF, HHA or CORF services, you will get written notice either from us or your provider at least 2 calendar days before your coverage ends. You (or someone you authorize) will be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that coverage should end – it only means that you received the notice.

How to to get a review of your coverage by the Quality Improvement Organization

You have the right by law to ask for an appeal of our termination of your coverage. As will be explained in the notice you get from us or your provider, you can ask the Quality Improvement Organization (the “QIO”) to do an independent review of whether our terminating your coverage is medically appropriate.

How soon you have to ask the QIO to review your coverage?

If you want to have the termination of your coverage appealed, you must act quickly to contact the QIO. The written notice you get from us or your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must be sure to make your request **no later than noon** of the day after you get the notice from your provider.
- If you get the notice and you have more than 2 days before your coverage ends, then you must make your request **no later than noon** the day before the date that your Medicare coverage ends.

What will happen during the review?

If the QIO reviews your case, the QIO will ask for your opinion about why you believe the services should continue. You do not have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review other information that we have given to the QIO. You and the QIO will each get a copy of our explanation about why your services should not continue.

After reviewing all the information, the QIO will give an opinion about whether it is medically appropriate for your coverage to be terminated on the date that has been set for you. The QIO will make this decision within one full day after it receives the information it needs to make a decision.

What happens if the QIO decides in your favor?

If the QIO agrees with you, then we will continue to cover your SNF, HHA or CORF services for as long as medically necessary.

What happens if the QIO denies your request?

If the QIO decides that our decision to terminate coverage was medically appropriate, you will be responsible for paying the SNF, HHA or CORF charges after the termination date on the advance notice you got from us or your provider. Neither Original Medicare nor the GHC MA Plan will pay for these services. If you stop receiving services on or before the date given on the notice, you can avoid any financial liability.

What if you do not ask the QIO for a review in time?

You still have another option: asking GHC for a “fast appeal” of your discharge

If you do not ask the QIO for a “fast appeal” of your discharge by the deadline, you can ask us for a “fast appeal” of your discharge. How to ask us for a fast appeal is covered briefly in the first part of this section and in more detail in Section 10.

If you ask us for a fast appeal of your termination and you continue getting services from the SNF, HHA or CORF, you run the risk of having to pay for the care you receive past your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to continue to get your services covered, then we will continue to cover your care for as long as medically necessary.
- If we decide that you should not have continued getting coverage for your care, then we will **not** cover any care you received if you stayed after the termination date.

You may have to pay if you stay past your discharge date. (The QIO does not decide in your favor.)

If you do not ask the QIO by noon after the day you are given written notice that we will be terminating coverage for your SNF, HHA or CORF services, and if you stay in the SNF, HHA or CORF after this date, you run the risk of having to pay for the SNF, HHA or CORF care you receive on and after this date. However, you can appeal any bills for SNF, HHA or CORF care you receive using Step 1 of the appeals process described in Section 10.

PART 4. Complaints (grievances) about any other type of problem you have with GHC, the GHC MA Plan, or one of our plan providers

This last part of Section 9 explains how to make complaints about any *other* type of problem that has not already been discussed earlier in this section. (The problems that have already been discussed are problems related to coverage or payment for care, problems about being discharged from the hospital too soon and problems about coverage for SNF, HHA or CORF services ending too soon.)

What is included in “all other types of problems”?

Here are some examples of problems that are included in this category of “all other types of problems”:

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
 - If you feel that you are being encouraged to leave (disenroll from) the GHC MA Plan.
 - Problems with the customer service you receive.
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- Problems with how long you have to spend waiting on the phone, in the waiting room, or in the exam room.
- Problems with getting appointments when you need them, or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.

If you have one of these types of problems and want to make a complaint, it is called “filing a grievance.” In addition, you have the right to ask for a “fast grievance” if you disagree with our decision to not give you a “fast appeal” or if we take an extension on our initial decision or appeal. See below for more detail.

Filing a grievance with the GHC MA Plan

If you have a complaint, we encourage you to first call GHC Customer Service at the number on the cover of this booklet.

We will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint we will respond in writing to you. Also, if we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this GHC's grievance procedure. For this process your grievance requests must be in writing, and mailed to GHC Customer Service Medicare Grievance, P.O. Box 34590, Seattle WA 98124-1590 or fax: 206-901-4612, or email info@ghc.org, or you may call the number on the cover of this booklet to contact GHC Customer Service. We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

For quality of care problems, you may also complain to the QIO

If you are concerned about the quality of care you received, including care during a hospital stay, you can also complain to an independent organization called the QIO. See Section 1 for more information about the QIO.

SECTION 10 Detailed information about how to make an appeal

What is the purpose of this section?

The purpose of this section is to give you more information about a topic that is summarized briefly in the previous section of this booklet (Section 9). Section 9 outlines the six possible steps in the appeals process for making complaints about your coverage or payment for your care. This section goes through the same six steps in more detail. Since Section 9 also gives general information about making complaints, and discusses how to deal with other types of problems besides problems with coverage or payment for care, **you should read Section 9 before you read this section.**

A note about terminology. In this Section, we tend to use simpler language instead of certain legal language, including terms that appear in the government regulations for the appeals process.

For example, we generally say “initial decision” instead of “initial organization determination,” and we generally use the word “fast” rather than “expedited” when referring to decisions that are made more quickly than the standard time frame. Instead of saying “adverse decision,” we may say “deny your request,” or “turn down your appeal.” We use “independent review organization” rather than “independent review entity.”

What are “complaints about your coverage or payment for your care”?

Complaints about your coverage or payment for your care are complaints you may have if you are not getting medical benefits and services you believe are covered for you as a plan member. This includes payment for care received while a member of the GHC MA Plan. Complaints about your coverage or payment for your care include complaints about the following situations:

- If you are not getting the care you want, and you believe that this care is covered by the GHC MA Plan
- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by the GHC MA Plan
- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health
- If you have received care that you believe is covered by the GHC MA Plan, but we have refused to pay for this care because we say it is not covered

How does the appeals process work?

The six possible steps you can take to make complaints related to your coverage or payment for your care are described below. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

- **Moving from one step to the next.** At each step, your request for care or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the medical care involved or on other factors.
- **“Initial decision” vs. “making an appeal.”** Step 1 deals with the starting point for the appeals process. The decision made in Step 1 is called an “initial decision” or “organization determination.” If you continue with your complaint by going on to Step 2, it is called making an “appeal” or a “request for reconsideration” of our initial decision because you are “appealing” for a change in the initial decision that was made in Step 1. Step 2, and all of the remaining possible steps, also involves *appealing* a decision.
- **Who makes the decision at each step.** In Step 1, you make your request for coverage of care or payment for care directly to us. We review this request, then make an initial decision. If our initial decision turns down your request, you can go on to Step 2, where you “appeal” this initial decision (asking us to reconsider). **After Step 2, your appeal goes outside of GHC, where people who are not connected to us conduct the review and make the decision.** To help ensure a fair, impartial decision, those who make the decision about your appeal in Steps 3-6 are part of (or in some way connected to) the Medicare program or the federal court system.

STEP 1: GHC makes an “initial decision” about your medical care, or

about paying for care you have already received

What is an “initial decision”?

The “initial decision” made by GHC is the starting point for dealing with requests you may have about your coverage or payment for your care. With this decision, we inform you whether we will provide the medical care or service you request, or pay for a service you have already received. (This “initial decision” is sometimes called an “organization determination.”) If our initial decision is to deny your request (this is sometimes called an “adverse initial decision”), you can “appeal” the decision by going on to Step 2 (see below). You may also go on to Step 2 if we fail to make a timely “initial decision” on your request.

- If you ask us to pay for medical care you have already received, this is a request for an “initial decision” about payment for your care. You can call us at 1-888-901-4636 to get help in making this request.
- If you ask for a specific type of medical treatment from your doctor or other medical provider, this is a request for an “initial decision” about whether the treatment you want is covered by the GHC MA Plan. Depending on the situation, your doctor or other medical provider may make this decision on behalf of GHC, or may ask us whether we will authorize the treatment. You may want to ask us for an initial decision without involving your doctor. You can call us at 1-888-901-7450 to ask for an initial decision.

When we make an “initial decision,” we are giving our interpretation of how the benefits and services that are covered for members of the GHC MA Plan apply to your specific situation. This booklet and any amendments you may receive describe the benefits and services covered by the GHC MA Plan, including any limitations that may apply to these services. This booklet also lists exclusions (services that are “not covered” by the GHC MA Plan).

Who may ask for an “initial decision” about your medical care or payment?

You can ask us for an initial decision yourself, or you can name someone to do it for you. This person you name would be your *authorized representative*. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under state law to act for you.

If you want someone to act for you, then you and the person you want to act for you, must sign and date a statement that gives this person legal permission to act for you. This statement must be sent to us at GHC, Medicare Appeals Coordinator at P.O. Box 34593, Seattle, WA 98124-1593. You can call us at 206-901-7450 toll-free 1-888-901-4636 or TTY at 711 or 1-800-833-6388 (If you have a hearing or speech impairment) to learn how to name your authorized representative.

You also have the right to have an attorney ask for an initial decision on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. You may want to contact SHIBA for assistance. Section 1, telephone numbers and other information, tells you how to contact the SHIBA helpline.

“Standard decisions” vs. “fast decisions” about medical care

Do you have a request for medical care that needs to be decided more quickly than the standard time frame?

A decision about whether we will cover medical care can be a “standard decision” that is made within the standard time frame (typically within 14 days; see below), or it can be a “fast decision” that is made more quickly (typically within 72 hours; see below). A fast decision is sometimes called a 72-hour decision or an “expedited organization determination.”

You can ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for medical care. You cannot get a fast decision on requests for payment for care you have already received.)

Asking for a standard decision

To ask for a standard decision about medical care or payment for care, you or your authorized representative should mail or deliver a request in writing to the following address: GHC, Medicare Appeals Coordinator at P.O. Box 34593, Seattle, WA 98124-1593.

Asking for a fast decision

You, any doctor, or your authorized representative can ask us to give a “fast” decision (rather than a “standard” decision) about medical care by calling us at 206-901-7350 or toll-free 1-888-901-4636 or TTY, at 711 or 1-800-833-6388 (this number requires special telephone equipment and is used by people who have difficulties with hearing or speaking) Or, you can deliver a written request to GHC, Medicare Appeals Coordinator at P.O. Box 34593, Seattle, WA 98124-1593 or fax it to 206-901-7340. Be sure to ask for a “fast” or “72-hour” review.

- If **any** doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast initial decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast initial decision, we will send you a letter informing you that if you get a doctor’s support for a “fast” review, we will automatically give you a fast decision. The letter will also tell you how to file a “grievance” if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast initial decision, we will instead give you a standard decision (typically within 14 calendar days; see below).

What happens when you request an “initial decision”?

What happens, including how soon we must decide, depends on the type of decision.

1. *For a decision about payment for care you already received.*

We have 30 calendar days to make a decision after we have received your request. However, if we need more information, we can take up to 30 more days. You will be told in writing when we make a decision.

If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 calendar days of your

request for payment, then the failure to receive an answer is the same as being told that your request was not approved. You may then appeal this decision. (An appeal is also called a reconsideration.) Step 2 tells how to file this appeal.

2. *For a standard initial decision about medical care.*

We have up to 14 calendar days to make a decision after we have received your request, but we will make it sooner if your health condition requires. However, we are allowed to take up to an additional 14 calendar days to make a decision if you request the additional time, or if we need more time to gather information that may benefit you. For example, we may need more time to get information that would help us approve your request for medical care (such as medical records). When we take additional days, we will notify you in writing of this extension. If you feel that we should not take additional days, you can make a specific type of complaint called a “grievance.” Section 9 of this booklet tells how to file a grievance.

We will tell you in writing of our initial decision concerning the medical care you have requested. You will receive this notification when we make our decision, under the time frame explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. Step 2 tells how to file this appeal.

If you have not received an answer from us within 14 calendar days of your request for the initial decision, the failure to receive an answer is the same as being told that your request was not approved, and you have the right to appeal. Step 2 tells how to file this appeal. If we tell you that we extended the number of days needed for a decision and you have not received an answer from us by the end of the extension period, the failure to receive an answer is the same as being told that your request was not approved, and you do have the right to appeal.

3. *For a fast initial decision about medical care.*

If you receive a “fast” review, we will give you our decision about your medical care within 72 hours after you or your doctor ask for a “fast” review—sooner if your health requires. However, we are allowed to take up to 14 more calendar days to make this decision if we find that some information is missing which may benefit you, or if you need more time to prepare for this review. If you feel that we should not take any additional days, you can make a specific type of complaint called a “grievance.” Section 9 of this booklet tells how to file a grievance.

We will tell you our decision by phone as soon as we make the decision. Within three calendar days after we tell you of our decision in person or by phone, we will send you a letter that explains the decision. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), this is the same as denying your request. If we deny your request for a fast decision, you may file a grievance. Section 9 of this booklet tells how to file a grievance.

What happens next if we decide completely in your favor?

If we make an “initial decision” that is completely in your favor, what happens next depends on the situation.

1. *For a decision about payment for care you already received.*

We must pay within 30 calendar days of your request for payment, unless your request has errors or missing information. Then, we must pay within 60 calendar days.

2. *For a standard decision about medical care.*

We must authorize or provide you with the care you have requested as quickly as your health requires, but no later than 14 calendar days after we received the request you made for the initial decision. If we extended the time needed to make the decision, we will approve or provide your medical care when we make our decision.

3. *For a fast decision about medical care.*

We must authorize or provide you with the medical care you have requested within 72 hours of receiving your request. If your health would be affected by waiting this long, we must provide it sooner.

What happens next if we deny your request?

If we deny your request, we may decide *completely* or only *partly* against you. For example, if we deny your request for payment for care that you have already received, we may say that we will pay nothing or only part of the amount you requested. In denying a request for medical care, we might decide not to approve any of the care you want, or only some of the care you want. If any initial decision does not give you all that you requested, you have the right to ask us to reconsider the decision (See Step 2).

STEP 2: If we deny part or all of your request in Step 1, you may ask us to reconsider our decision. This is called an “appeal” or “request for reconsideration.”

Please call us at 1-888-901-4636 or TTY at 711 or 1-800-833-6388 (this number requires special telephone equipment and is used by people who have difficulties with hearing or speaking), if you need help in filing your appeal. You may ask us to reconsider the initial decision we made in Step 1, even if only part of our decision is not what you requested. When we receive your request to reconsider the initial decision, we give the request to different people than those who were involved in making the initial decision. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether it is about payment for care you already received, or about authorizing medical care. If your appeal concerns a decision we made about authorizing medical care, then you and/or your doctor will first need to decide whether you need a “fast” appeal. The procedures for deciding on a “standard” or a “fast” *appeal* are the same as those described for a “standard” or “fast” *initial* decision in Step 1. Please see the discussion in Step 1 under “Do you have a request for medical care that needs to be decided more quickly than the standard time frame?” and “Asking for a fast decision.”

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get the doctor’s records or the doctor’s opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing, to GHC, Medicare Appeals Coordinator at P.O. Box 34593, Seattle, WA 98124-1593.
- By fax, at 206-901-7340.
- By telephone—if it is a “fast” appeal—at 206-901-4636 or the toll-free 1-888-901-4636 or TTY at 711 or 1-800-833-6388 (this number requires special telephone equipment and is used by people who have difficulties with hearing or speaking).
- In person, at 12400 East Marginal Way South, Tukwila, WA 98168-2559

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us and ask for a copy of your file at 1-888-901-4636, GHC, Medicare Appeals Coordinator at P.O. Box 34593, Seattle, WA 98124-1593. A fee maybe charged: We are allowed to charge a fee for copying and sending this information to you.

How do you file your appeal of the initial decision?

The rules about who may file an appeal in Step 2 are the same as the rules about who may ask for an “initial decision” in Step 1. Follow the instructions in Step 1 under “Who may ask for an ‘initial decision’” about medical care or payment?”

Either you, your representative (someone you appoint), or your provider may file this appeal.

However, providers who do not have a contract with GHC must sign a “waiver of payment” statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

The appeal should be given to us in writing at GHC, Medicare Appeals Coordinator at P.O. Box 34593, Seattle, WA 98124-1593, within 60 calendar days after we notify you of the initial decision from Step 1. We can give you more time if you have a good reason for missing the deadline.

What if you want a “fast” appeal?

The rules about asking for a “fast” appeal in Step 2 are the same as the rules about asking for a “fast” initial decision in Step 1. If you want to ask for a “fast” appeal in Step 2, please follow the instructions in Step 1 under “Asking for a fast decision.”

How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. *For a decision about payment for care you already received.*

After we receive your appeal, we have 60 calendar days to make a decision. If we do not decide within 60 calendar days, your appeal *automatically* goes to Step 3, where an independent organization will review your case.

2. *For a standard decision about medical care.*

After we receive your appeal, we have up to 30 calendar days to make a decision, but will make it sooner if your health condition requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 30 calendar days (or by the end of the extended time period), your request will *automatically* go to Step 3, where an independent organization will review your case.

3. *For a fast decision about medical care.*

After we receive your appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires.

However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will automatically go to Step 3, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. *For a decision about payment for care you already received.*

We must pay within 60- calendar days of the day we received your request for us to reconsider our initial decision. If we decide only partially in your favor, your appeal automatically goes to Step 3, where an independent organization will review your case.

2. *For a standard decision about medical care.*

We must authorize or provide you with the care you have asked for as quickly as your health requires, but no later than 30 calendar days after we received your appeal. If we extend the time needed to decide your appeal, we will authorize or provide your medical care when we make our decision.

3. *For a fast decision about medical care.*

We must authorize or provide you with the care you have asked for within 72 hours of receiving your appeal—or sooner, if your health would be affected by waiting this long. If we extended the time needed to decide your appeal, we will authorize or provide your medical care at the time we make our decision.

What happens next if we deny your appeal?

If we deny any part of your appeal in Step 2, then your appeal *automatically* goes on to Step 3 where an independent organization will review your case. This independent review organization contracts with the federal government and is not part of GHC. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal to the independent review organization that performs the review in Step 3 depends on the type of appeal:

1. *For a decision about payment for care you already received.*

We must send all the information about your appeal to the independent review organization within 60 calendar days from the date we received your appeal in Step 2.

2. *For a standard decision about medical care.*

We must send all of the information about your appeal to the independent review organization as quickly as your health requires, but no later than 30 calendar days after we received your appeal in Step 2.

3. *For a fast decision about medical care.*

We must send all of the information about your appeal to the independent review organization within 24 hours of our decision.

STEP 3: If we deny any part of your appeal in Step 2, your appeal automatically goes on for review by a government-contracted independent review organization

What independent review organization does this review?

In Step 3, your appeal is given a new review by an outside, independent review organization that has a contract with CMS (Centers for Medicare & Medicaid Services), the government agency that runs the Medicare program. This organization has no connection to GHC. We will tell you when we have sent your appeal to this organization. You have the right to get a copy from us of your case file that we sent to this organization. You may be charged a fee: We are allowed to charge you a fee for copying and sending this information to you.

How soon must the independent review organization decide?

After the independent review organization receives your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. **For an appeal about payment for care**, the independent review organization has up to 60 calendar days to make a decision.
2. **For a standard appeal about medical care**, the independent review organization has up to 30 calendar days to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.
3. **For a fast appeal about medical care**, the independent review organization has up to 72 hours to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. **For an appeal about payment for care**,

We must pay within 30 calendar days after receiving the decision.

2. **For a standard appeal about medical care**,

We must *authorize* the care you have asked for within 72 hours after receiving notice of the decision from the independent review organization, or *provide* the care as quickly as your health requires, but no later than 14 calendar days after receiving the decision.

3. **For a fast appeal about medical care**,

We must authorize or provide you with the care you have asked for within 72 hours of receiving the decision.

What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You may continue your appeal by asking for a review by an Administrative Law Judge (see Step 4), provided that the dollar value of the medical care or the payment in your appeal is \$110 or more.

You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date you were notified of the decision made in Step 3. You can extend this deadline for good cause. You must send your written request to the entity specified in the decision made in Step 3.

STEP 4: If the organization that reviews your case in Step 3 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated in Step 3, if the independent review organization does not rule completely in your favor, you may ask them to forward your appeal for a review by an Administrative Law Judge. During this review, you may present evidence, review the record, and be represented by council. The Administrative Law Judge will not review the appeal if the dollar value of the medical care is less than \$110. If the dollar value is less than \$110, you may not appeal any further.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor

We must pay for, authorize, or provide the service you have asked for within 60 calendar days from the date we receive notice of the decision. We have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Step 5).

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Step 5). The letter you get from the Administrative Law Judge will tell you how to request this review.

STEP 5: Your case may be reviewed by a Medicare Appeals Council This Council will first decide whether to review your case

The Medicare Appeals Council does not review every case it receives. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then either you or the GHC MA Plan may request a review by a Federal Court Judge. However, the Federal Court Judge will only review cases when the amount involved is \$1,090 or more. If the dollar value is less than \$1,090, you may not appeal any further.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor

We must pay for, authorize, or provide the medical service you have asked for within 60 calendar days from the date we receive notice of the decision. However, we have the right to appeal this decision by asking a Federal Court Judge to review the case (Step 6), provided the amount involved is at least \$1,090. If the dollar value is less than \$1,090, the Council's decision is final.

If the Council decides against you

If the amount involved is \$1,090 or more, you or we have the right to continue your appeal by asking a Federal Court Judge to review the case (Step 6). If the value is less than \$1,090, you may not take the appeal any further.

STEP 6: Your case may go to a Federal Court

If the contested amount is \$1,090 or more, you or we may ask a Federal Court Judge to review the case.

SECTION 11 Leaving the GHC MA Plan and your choices for continuing Medicare after you leave

What is disenrollment?

“Disenrollment” from the GHC MA Plan means **ending your membership in** the GHC MA Plan. Disenrollment can be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave the GHC MA Plan because you have decided that you *want* to leave. You can do this for any reason. However, as we explain in this section, **there are limits to when you may leave, how often you can make changes, and what type of plan you can join after you leave.**
- There are also a few situations where you would be *required* to leave. For example, you would have to leave the GHC MA Plan if you move out of our geographic service area or if the GHC MA Plan leaves the Medicare program. We are not allowed to ask you to leave the plan because of your health.

Whether leaving the plan is your choice or not, this section explains your Medicare coverage choices after you leave and the rules that apply.

Until your membership officially ends, you must keep getting your Medicare services through the GHC MA Plan or you will have to pay for them yourself

If you leave the GHC MA Plan, it takes some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect later in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care as usual through the GHC MA Plan.

If you get services from doctors or other medical providers who are **not** plan providers before your membership in the GHC MA Plan ends, neither GHC nor the Medicare program will pay for these services, with just a few exceptions. The exceptions are urgently needed care, care for a medical emergency, out-of-area renal (kidney) dialysis services, care that has been approved by us, and services that we denied but that were overturned in an appeal. There is another possible exception, if you happen to be hospitalized on the day your membership ends. If this happens to you, call GHC Customer Service at the number on the cover of this booklet to find out if the GHC MA Plan will cover your hospital care. If you have any questions about leaving the GHC MA Plan, please call us at GHC Customer Service.

What are your choices for continuing Medicare if you leave the GHC MA plan?

If you leave the GHC MA Plan, one choice for continuing with Medicare is to join another **Medicare Advantage Plan** or a **Medicare Private Fee-for-Service plan** *if* any of these types of plans are available in your area and they are accepting new members. You can also choose to go to **Original Medicare**.

- **Original Medicare** is available throughout the country. It is a pay-per-visit or “fee-for-service” health plan that lets you go to any doctor, hospital, or other health care provider *who accepts Medicare*. You must pay a deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).
- **Medicare Advantage Plans** (such as HMOs or PPOs) are available in some parts of the country. In HMOs you go to the doctors, hospitals, and other providers *that are part of the plan*. In PPOs, you can usually see any doctor but you will pay more to see doctors, hospitals, and other providers that are *not* part of the plan. These plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs as part of the Medicare Part D (Prescription Drug) benefit. You may only change during certain times of the year (see “When and how often can you change your Medicare choices?” below.)
- **Medicare Private Fee-for-Service Plans** are available in some parts of the country. In Private Fee-for-Service plans, you may go to *any* Medicare-approved doctor or hospital that accepts the plan’s payment. The Private Fee-for-Service plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more for Medicare-covered benefits. You may get extra benefits that Original Medicare does not cover. Like prescription drugs as part of the Medicare Part D (Prescription Drug) benefit. For more information on when you can make changes see “When and how often can you change your Medicare choices?” below. Private Fee-for-Service plans are *not* the same as Medigap (Medicare supplement insurance) policies.

When and how often can you change your Medicare choices, and what choices can you make?

Starting in 2006, there are limits to when and how often you can change the way you get Medicare and what choices you can make when you make the change.

Here are the new rules:

1. From November 15, 2005 through May 15, 2006, anyone with Medicare will have two changes to switch from one way of getting Medicare to another.
2. From January 1, 2006 until June 30, 2006, anyone with Medicare has another chance to make one change in the way they get Medicare.

With this chance, you are limited in the type of plan you may join. If you have Medicare prescription drug coverage when making your change, you will only be able to join a Medicare Advantage Plan or Medicare Private Fee-For-Service plan that offers the Medicare Part D (Prescription Drug), or you will have to go to Original Medicare and join a Prescription Drug Plan. If you do not have prescription drug coverage when making this change, you will only be able to join a Medicare Advantage Plan or Medicare Private Fee-For-Service plan that does not offer the Medicare Part D (Prescription Drug), or go to Original Medicare.

3. Generally, you can't make any other changes during the year unless you meet special exceptions, such as if you move or if you have Medicaid coverage. Contact us for information. Later in the year, from November 15 through December 31, anyone with Medicare can switch their way of getting Medicare to another way for the following year.

In most cases, your disenrollment date will be the first day of the month that comes *after* the month we receive your request to leave. For example, if we receive your request to leave during the month of February, your disenrollment date will be March 1.

What should you do if you decide to leave the GHC MA plan?

If you want to leave the GHC MA Plan:

- The first step is to **be sure that the type of change you want to make and when you want to make it fit with the new rules** explained above about changing how you get Medicare. If the change does not fit with these rules, you won't be allowed to make the change.
- Then, what you must do to leave the GHC MA plan depends on whether you want to switch to Original Medicare or to one of your other choices.

How to change from the GHC MA Plan to Original Medicare

Do you need to join a Prescription Drug Plan?

Original Medicare does not cover very many prescription drugs outside of a hospital. So, if you want to change from the GHC MA Plan to Original Medicare, you should think about whether you want to also join a Medicare Prescription Drug Plan. It is important to know that if you are eligible to join a

prescription drug plan and you do not, you may have to pay a higher premium when you do join. To get information about Prescription Drug Plans that you can join, you can call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY Users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Keep in mind that if you change from the GHC MA Plan to Original Medicare, the only times that you can also join a Prescription Drug Plan are from January 1, 2006 to May 15, 2006, from November 15, 2006 to December 31, 2006, or during a special enrollment period as described in “When and how often can you change your Medicare choices and what choices can you make during these times?”

Do you need to buy a Medigap (Medicare supplement insurance) policy?

If you want to change from the GHC MA Plan to Original Medicare, you should think about whether you need to buy a Medigap policy to supplement your Original Medicare coverage. For Medigap advice, you should contact SHIBA the phone number is in Section 1). You can ask SHIBA about how and when to buy a Medigap policy if you need one. SHIBA can tell you if you have a guaranteed issue right to buy a Medigap policy.

If you are at least 65 and have been eligible for Part B for less than six months, you may still be in your Medigap open enrollment period. If you leave our plan while you are still in your open enrollment period, and you do not have a guaranteed issue right, the Medigap insurer can refuse to sell you a policy, or impose limits based on your health. If you have a “**guaranteed issue right**,” this means that the Medigap insurer must sell you a Medigap policy, even if you have health problems. This is a special, temporary right, which means that if you decide to change to Original Medicare you have a limited time to buy a Medigap policy on a guaranteed issue basis. For example, you have a guaranteed issue right to buy a Medigap policy if you are in a “trial period.

You may be in a trial period if in the past 12 months you: (1) dropped a Medigap policy to join the GHC MA plan or Medicare health plan for the first time; or (2) joined the GHC MA plan or another Medicare health plan when you first became entitled to Medicare at age 65. Under certain circumstances, if you lose your health plan coverage while you are still in a trial period, the trial period can last for an extra 12 months. SHIBA can tell you about other situations where you may have guaranteed issue rights. You may also have a guaranteed issue right if you move out of our service area, or if we stop providing Medicare benefits.

If you do buy a Medigap policy, you still have to follow the instructions below for changing from the GHC MA Plan to Original Medicare. (Buying a Medigap policy does not switch you from the GHC MA Plan to Original Medicare. A Medigap sales person or insurance agent cannot cancel your GHC MA Plan membership and put you in Original Medicare.)

How to change from the GHC MA Plan to Original Medicare

If you decide to change from the GHC MA Plan to Original Medicare, you must tell us (or one of the offices listed below) that you want to leave the GHC MA Plan. You do *not* have to notify Original Medicare, because you will automatically be in Original Medicare when you leave the GHC MA Plan. Here is how it works:

1. First, use any of the following ways to tell us that you want to leave the GHC MA Plan:

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- You can write or fax a letter to us or fill out a disenrollment form and send it to GHC Medicare Enrollment and Reconciliation, P.O. Box 34255, Seattle WA 98124-9986 or to our fax number at 206-988-7543. Be sure to sign and date your letter and or form. To get a disenrollment form, call us at GHC Customer Service the telephone number is on the cover of this booklet.
 - You can call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY Users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.
2. We will respond by sending you a letter that tells you when your membership will end. This is your **disenrollment date** – the day you officially leave the GHC MA Plan. In most cases, your disenrollment date will be the first day of the month that comes after the month we receive your request to leave. For example, if we receive your request to leave during the month of February, your disenrollment date will be March 1. Remember, while you are waiting for your membership to end, you are still a member of the GHC MA Plan and must continue to get your medical care as usual through the GHC MA Plan.
 3. On your disenrollment date, your membership in the GHC MA Plan ends, and you can start using your red, white, and blue Medicare card to get services under Original Medicare. You will not get anything in writing that tells you that you have Original Medicare, because you will *automatically* be in Original Medicare when you leave the GHC MA Plan. (If you need a new red, white, and blue Medicare card, call Social Security at 1-800-772-1213. The TTY number is 1-800-325-0778 (you need special telephone equipment to use this number). Calls to these numbers are free.)

How to change from the GHC MA Plan to another Medicare Advantage Plan or to a Private Fee-for-Service Plan

If you want to change from the GHC MA Plan to a different Medicare Advantage Plan or to a different Private Fee-for-Service plan, here is what to do:

1. Contact the plan you want to join to be sure it is accepting new members. You can only change plans from January 1, 2006 to May 15, 2006, from November 15, 2006 to December 31, 2006 or during an “exception for special circumstances” as described in “When and how often can you change your Medicare choices and what choices can you make during these times?”
2. If the plan is accepting new members, apply for membership in the plan. **Once you are enrolled in your new plan, your membership in the GHC MA Plan will *automatically* end.** This means that you do not need to tell us that you are leaving. However, we do encourage you to tell us why you left.
3. Your new plan will tell you in writing the date when your membership in that plan begins, and your membership in the GHC MA Plan will end on that same day (this will be your “disenrollment date”). Remember, you are still a member until your disenrollment date, and must continue to get your medical care as usual through the GHC MA Plan until the date your membership ends.

What happens to you if GHC leaves the Medicare program or the GHC MA Plan leaves the area where you live?

If we leave the Medicare program or change our service area so that it no longer includes the area where you live, we will tell you in writing. If this happens, your membership in the GHC MA Plan will end, and you will have to change to another way of getting your Medicare benefits. All of the benefits and rules described in this booklet will continue until your membership ends. This means that you must continue to get your medical care in the usual way through the GHC MA Plan until your membership ends.

Your choices for how to get your Medicare will always include Original Medicare and joining a Prescription Drug Plan to complement your Original Medicare coverage. Your choices may also include joining another Medicare Advantage Plan, or a Private Fee-for-Service plan, if these plans are available in your area and are accepting new members. Once we have told you in writing that we are leaving the Medicare program or the area where you live, you will have a chance to change to another way of getting your Medicare benefits. If you decide to change from the GHC MA Plan to Original Medicare, you will have the right to buy a Medigap policy regardless of your health. This is called a “guaranteed issue right” and it is explained earlier in this section under the heading, “Do you need to buy a Medigap (Medicare supplement insurance) policy?”

GHC has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract renews each year. At the end of each year, the contract is reviewed, and either GHC or CMS can decide to end it. You will get 90 days advance notice in this situation. It is also possible for our contract to end at some other time, too. In these situations we will try to tell you 90 days in advance, but you advance notice may be as little as 30 days or even fewer days if CMS must end our contract in the middle of the year.

Whenever a Medicare health plan leaves the Medicare program or stops servicing your area, you will be provided a special enrollment period to make choices about how you get Medicare, including choosing a Medicare Prescription Drug Plan and guaranteed issue rights to a Medigap policy.

You must leave the GHC MA Plan if you move out of the service area or are away from the service area for more than six months in a row

If you plan to move or take a long trip, please call GHC Customer Service at the number on the cover of this booklet to find out if the place you are moving to or traveling to is in your plan’s service area. If you move permanently out of our service area, or if you are away from our service area for more than six months in a row, you generally cannot remain a member of the GHC MA Plan and you will need to leave (“disenroll” from) the GHC MA Plan. In these situations, if you do not leave on your own, we must end your membership (“disenroll” you). An earlier part of this section tells about the choices you have if you leave the GHC MA Plan and explains how to leave. Section 2 gives more information about getting care when you are away from the service area.

Under certain conditions GHC can end your membership and make you leave the plan

We *cannot* ask you to leave the plan because of your health

No member of any Medicare health plan can be asked to leave the plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave the GHC MA Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), which is the national Medicare help line. You can call 24 hours a day 7 days a week.

We *can* ask you to leave the plan under certain special conditions

If any of the following situations occur, we will need to end your membership in GHC.

- If you move out of our geographic service area or live outside the plan's service area for more than six months at a time. (See Section 2 for information about the plan's service area).
- If you do *not* stay continuously enrolled in both Medicare Part A and Medicare Part B (see Section 7 for information about staying enrolled in Part A and Part B).
- If you give us information on your enrollment form that you know is false or deliberately misleading, and it affects whether or not you can enroll in the GHC MA Plan.
- If you behave in a way that is disruptive to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of the GHC MA Plan. We cannot make you leave the GHC MA Plan for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.
- If you do not pay the plan premiums, we will tell you that you have a 60-day grace period during which you can pay the plan premiums before you are required to leave the GHC MA Plan.

You have the right to make a complaint if we ask you to leave GHC

If we ask you to leave the GHC MA Plan we will tell you our reasons in writing and explain how you can file a complaint against us if you want to.

SECTION 12 Legal Notices

Notice about governing law

Many different laws apply to this Evidence of Coverage. Some additional provisions may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the State of Washington and the United States of America may apply.

Notice about non-discrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like GHC, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

Section 13 Definitions of some words used in this booklet

For the terms listed below, this section either gives a definition or directs you to a place in this booklet that explains the term

Appeal – A type of complaint you make when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service. Sections 9 and 10 explain about appeals, including the process involved in making an appeal.

Benefit period – For both the GHC MA Plan and Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period *begins* on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period *ends* when you have not been an inpatient at any hospital or SNF care for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The type of care you actually receive during the stay determines whether you are considered to be an inpatient for SNF stays, but not for hospital stays.

- You are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care standards. Specifically, in order to have been an inpatient while in a SNF, you must need daily skilled nursing or skilled rehabilitation care, or both. (Section 6 tells what is meant by skilled care.)
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- Generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital (the type of care you actually receive in the hospital does not determine whether you are considered to be an inpatient in the hospital).

Centers for Medicare & Medicaid Services (CMS) -- The Federal Agency that runs the Medicare program (CMS was formerly known as the Health Care Financing Administration). Section 1 tells how you can contact CMS.

Copayment – Payment you make for your share of the cost of certain covered services you receive. A copayment is a **set amount per service** (such as paying \$15 for a doctor visit). You pay it when you get the service. The Benefits Chart in Section 4 gives your copayments for covered services.

Coverage Determination – The plan has made a coverage determination when it makes a decision about a benefit you can receive under the plan and the amount you must pay for the benefit.

Covered services – The general term we use in this booklet to mean all of the health care services and supplies that are covered by the GHC MA Plan. Covered services are listed in the Benefits Chart in Section 4.

Creditable Coverage – Coverage that is at least as good as the standard Medicare prescription drug coverage.

Disenroll or disenrollment—The process of ending your membership in the GHC MA Plan. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 11 tells about disenrollment.

Durable medical equipment - Equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment include wheelchairs, hospital beds, or equipment that supplies a person with oxygen.

Emergency Medical Condition - A medical condition brought on by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that not getting immediate medical attention could result in 1) Serious jeopardy to the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child); 2) Serious impairment to bodily functions; or 3) Serious dysfunction of any bodily organ or part.

Emergency care—Covered services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. Section 3 tells about emergency services.

Evidence Of Coverage and disclosure information—This document, along with your enrollment form and any other addendum we send you, which explains the covered services, defines our obligations, and explains your rights and responsibilities as a member of the GHC MA Plan.

GHC Customer Service—A department within GHC responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 1 for information about how to contact GHC Customer Service.

Grievance – A type of complaint you make about us or one of our plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve payment or coverage disputes. See Section 9 for more information about grievances.

Inpatient Care – Health care that you get when you are admitted to a hospital.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you don't join a plan when you're first able. You pay this higher amount as long as you have Medicare. There are some exceptions. If you do not have credible prescription drug coverage, you will have to pay a penalty in addition to your monthly plan premium.

Lock-In—An arrangement under which some services of a specialist must be provided or authorized by your plan provider or your PCP. If you get some services of a specialist from a non-plan provider, without prior authorization, neither GHC nor Original Medicare will pay for that care. There are some exceptions to this rule. For more information, see Section 2, “Getting the care you need, including some rules you must follow”, under the heading “There are some services you can get on your own without a referral” regarding; covered emergency services from non-plan or plan providers, covered urgently needed services from non-plan or plan providers, out-of-area renal dialysis services from non-plan or plan providers, self-referral for Flu Shots from plan providers, Mammography Screening services from plan providers and some services of Group Health specialists at Group Health-operated medical centers only. See Section 3 for more information on; covered emergency services from non-plan or plan providers, covered urgently needed services from non-plan or plan providers, out-of-area renal dialysis services from non-plan or plan providers. See Section 4 for benefits that apply to self-referrals.

Medically necessary – Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.

Medicare—The federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Organization—A public or private organization licensed by the State as a risk-bearing entity that is under contract with the Centers for Medicare & Medicaid Services (CMS) to provide covered services. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans. GHC is a Medicare Advantage Organization. (Medicare Advantage is the new name for Medicare+Choice).

Medicare Advantage Plan—A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. A Medicare Advantage Organization may offer more than one plan in the same service area. The GHC MA Plan is a Medicare Advantage Plan.

Medicare Managed Care Plan – Means a Medicare Advantage HMO, Medicare Cost Plan, or Medicare Advantage PPO.

Medicare Prescription Drug Coverage – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B.

“Medigap” (Medicare supplement insurance) policy – Many people who get their Medicare through Original Medicare buy “Medigap” or Medicare supplement insurance policies to fill “gaps” in Original Medicare coverage.

Member (member of GHC MA Plan, or “plan member”) - A person with Medicare who is eligible to get covered services, who has enrolled in the GHC MA Plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services (Customer Service) – A Department within GHC – Group Health Customer Service - responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 1 for information about how to contact Customer Service.

Non-plan provider or non-plan facility—A provider or facility that we have **not** arranged with to coordinate or provide covered services to members of the GHC MA Plan. Non-plan providers are providers that are not employed, owned, or operated by GHC and are not under contract to deliver covered services to you. As explained in this booklet, most services you get from non-plan providers are not covered by GHC or Original Medicare.

Organization Determination – The MA organization has made an organization determination when it, or one of its providers, makes a decision about MA services or payment that you believe you should receive.

Original Medicare—Some people call it “traditional Medicare” or “fee-for-service” Medicare. Original Medicare is the way most people get their Medicare Part A and Part B health care. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider *who accepts Medicare*. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Part D – The voluntary Prescription Drug Benefit Program. (For ease of reference, we will refer to the new prescription drug benefit program as Part D.

Part D Drugs – Any drug that can be covered under a Medicare Prescription Drug Plan. Generally, any drug not specifically excluded under Medicare drug coverage is considered a Part D. Drug.

Plan provider – “**Provider**” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “**plan providers**” when they are part of the GHC MA Plan. When we say that plan providers are “part of the GHC MA Plan,” this means that we have arranged with them to coordinate or provide covered services to members of the GHC MA Plan.

Point of Service [POS] –When a member is out of the plan’s service area for up to six months at a time, non-emergent and/or non-urgently needed Medicare-covered care received while temporarily traveling outside GHC’s Medicare Service Area is payable at Medicare benefit levels up to \$2,000 per member per calendar year. Plan pays 80% of Medicare allowable reimbursement schedules for Medicare covered services ONLY. Member is responsible for all Medicare inpatient and outpatient deductibles and coinsurances. See Benefit grid for details. Member may not be out of the plan’s service area for more than six months at a time.

Primary Care Physician (PCP) -- A health care professional who is trained to give you basic care. Your PCP is responsible for providing or authorizing covered services while you are a plan member. Section 2 tells more about PCPs.

Prior authorization - Approval in advance to get services. Some services are covered only if your doctor or other plan provider gets “prior authorization” from GHC. Covered services that need prior authorization are marked in the Benefits Chart.

Quality Improvement Organization (QIO) - Groups of practicing doctors and other health care experts who are paid by the Federal Government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by doctors in inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private fee-for-service plans and ambulatory surgical centers. See Section 1 for information about how to contact the QIO in Washington State (Qualis Health) and Section 9 for information about making complaints (appeals or grievances) to the QIO.

Referral -- Your PCP’s approval for you to see a certain specialist or to receive certain covered services.

Rehabilitation services – These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider. Medicare will limit how much it covers for certain therapy services starting January 1, 2006. For total physical and speech therapy services, Medicare will cover up to \$1,750 a year; For occupational therapy services Medicare will cover up to \$1,750 a year. These limits apply to outpatient therapy services provided in outpatient medical centers and skilled nursing facilities. See Section 4 for more information.

Service area—Section 2 tells about the GHC MA Plan’s service area. “Service area” is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan.

Urgently needed care – Section 3 explains about urgently needed services. These are different from emergency services.

Usual, Customary And Reasonable (UCR) - A term used to define the level of benefits which are payable by GHC when expenses are incurred from a non-GHC provider. Expenses are considered Usual Customary and Reasonable if the charges are consistent with those normally charged to other by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies.